ORIGINAL

David E. Comstock LAW OFFICES OF COMSTOCK & BUSH 199 N. Capitol Blvd., Suite 500 P.O. Box 2774 Boise, Idaho 83701-2774 (208)344-7700 ISB No.: 2455

U.S. DISTRICT COURT_ U.S. BANKRUPTCY COURT_ DISTRICT OF IDAHO

OCT 29 2003

__ M. REC'D _

Attorneys for Plaintiff

i.	.00GED FILED	-
	_	

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

CHRIS J. DENNISON	Case No.: CV02-0507-S-LMB
Plaintiff,	AFFIDAVIT OF DAVID E. COMSTOCK
v .	
CONTINENTAL CASUALTY COMPANY) an Illinois corporation; CNA GROUP LIFE ASSURANCE COMPANY, a wholly owned subsidiary of Continental Casualty Company, RURAL TELEPHONE COMPANY, and Idaho corporation	
Defendants.))
STATE OF IDAHO)	
County of Ada)	

I, David E. Comstock, being first duly sworn upon oath, depose and state as

follows:

AFFIDAVIT OF DAVID E. COMSTOCK - 1

I am the attorney for the Plaintiff in the instant matter, and as such have personal knowledge of the facts set forth herein.

- Attached hereto as Exhibit A, is a true and correct copy of the Administrative Record in this matter; and
- Attached hereto as Exhibit B, is a true and correct copy of the ORDER in the matter of Casper v. Idaho Fresh Pak, Inc., United States District Court, District of Idaho, Case No.: CV 00-349-E-MHW.

Further your Affiant saith naught.

Dated this 29 to day of October, 2003.

David E. Comstock

SUBSCRIBED AND SWORN to before me this 29 day of October, 2003.

NOTARY PUBLIC

Notary Public for the State of

Idaho, residing at 💢

My Commission Expires: 5/2 L/10/a

CERTIFICATE OF SERVICE

I hereby certify that on this $2^{\frac{1}{2}}$ day of October, 2003, I served a true and correct copy of the above and foregoing instrument, by method indicated below, upon:

M

Facsimile (208) 344-5510

Hand Delivery

U.S.Mail

Robert A. Anderson Phil Collaer ANDERSON JULIAN & HULL 250 S. 5th Street, Suite 700 PO Box 7426 Boise ID 83707-7426 Attorneys for Defendant Rural

Idaho Falls, ID 83402-2948

Attorneys for Defendants CNA & Continental

Attorneys for Defendant Rural

Donald F. Carey

Robert D. Williams

QUANE SMITH

2325 W. Broadway, Suite B

[1] Facsimile (208)529-0005

Hand Delivery

U.S.Mail

Claim Analysis Record

aim Number:	<u> 339:</u>	56341	<u>_</u> 2	Da	te of Noti	ce:	2/,	, 19/02	۲.
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PO Box 946710 Maitland FL 32794

Doris Gloss RN

Appeals Committee Member

Telephone 800-303-9744 x6272

Facsimile 407-919-6574

June 24, 2002

Chris Dennison 9975 W Hollandale Drive Boise, ID 83709

Claim Number: 2395634 Policy Number: 83116494

Underwritten by: Continental Casualty Company

Services provided by: CNA Group Life Assurance Company

Dear Mr. Dennison,

Appeals completed a comprehensive review of your long-term disability claim as requested. Our review is based on the medical evidence that was submitted to CNA and was relied upon to conclude the determination of long-term disability benefits. After review of your file, in its totality, we must reaffirm the denial of benefits based on the following medical evidence and policy provisions. Appeals agreed with the intent, content, and conclusion brought forth by the denial letter written on 3/15/02 and some information may not be repeated.

According to the policy provisions: "Disability" means that during the Elimination Period and following 24 months, Injury or Sickness causes physical or mental impairment to such a degree of severity that You are:

- continuously unable to perform the Material and Substantial Duties of Your Regular Occupation;
 and
- 2. not working for wages in any occupation for which You are or become qualified by education, training or experience."

According to the information within your file, you ceased work on 2/7/02 due to back pain.

Dr. Frizzell filled out a physician's statement listing your diagnosis failed back syndrome, status post lumbar, and cervical surgeries. You complained of constant neck and back pain from multiple past surgeries. Dr. Frizzell listed your physical limitation as no lifting, pushing/pulling over 5 pounds. No prolong sitting or standing and only occasional bending and twisting.

Your employer submitted a job activity statement listing the physical requirement for the occupation as a Controller. The physical requirements that were provided were listed as follows: sitting for 10 to 12 hours with 1 to 2 hours of standing and walking per day. Occasional lifting boxes containing per and records from 20 to 50 pounds were required. You employer stated that lifting boxes were not a necessary part of your occupation and lifting could be accommodated.

A cervical spine x-ray was performed on 1/29/02 showing a solid appearing fusion from C5-6 and mild to moderate disc degeneration. The spine was in normal alignment with no fractures or subluxation and the prevertebral soft tissues were unremarkable. A lumbar spine x-ray was also performed on the same date that showed mild to moderate degenerative disk disease, no spondylolysis or spondylolisthesis.

An MRI of the entire spine was performed on 2/4/02 that the cervical spine showed there was no evidence of disk herniation, degenerative changes and posterior disk bulges were identified; however the cervical cord maintained normal size, shape and signal throughout. The thoracic spine showed a normal signal with mild degenerative changes without evidence of spinal stenosis or neural foraminal narrowing. The lumbar spine showed mild changes of degenerative disk disease and small postural protrusion with mild to moderate stenosis without herniation.

Dr. Frizzell submitted a correspondence dated 5/21/02, indicating that you have been under his care for low back and cervical neck surgeries and that you are disabled for your spine condition. Dr. Frizzell noted that you are not able to work with accommodations and you have rheumatological disease with positive lupus studies. On 3/21/02, Dr. Fizzell submitted a positive titer for anti-nuclear. The laboratory noted that a positive ANA result may be seen in a variety of diseases and healthy individuals. Its interpretation depends on clinical findings and other laboratory data. An ESR was also performed (a nonspecific test used to detect illness associated with acute and chronic infection or inflation. This test result was normal (2), (normal is 0-20).

While we acknowledge the medical tests may have revealed some abnormal findings; there were no physical examination within your claim file performed by your physicians to correlate clinical findings. Dr. Frizzell provided restrictions in the physician's statement that fell within the material and substantial duties of your occupation as a Controller. Lifting 20 to 50 pounds of boxes containing papers was listed as occasional, which would not be a material and substantial requirement of your occupation. Dr. Frizzell then submitted a correspondence noting that you would not be able to perform your occupation with accommodations; however, he did not submitted any evidence to support a functional impairment that would prevent you from performing your occupation.

Dr. Firzzell indicated that you also had a history of lupus and submitted a positive titer; however, your ESR (erythrocyte sedimentation rate) rate that would show an inflammatory process occurring within the body was low normal. Please be advised that verification of a condition does not confirm the inability to perform one's occupation, nor does it prove a disability.

Dr. Frizzell submitted a correspondence dated 4/22/02 noted that you were under his care for failed back syndrome and a history of lupus and had multiple surgeries, intractable back, neck and leg pain. Dr. Frizzel further noted that you are disabled from these conditions and were not able to engage in any kind of work. We acknowledge that you may have undergone back and neck surgery from 1997 and 1998, the evidence showed that your fusion was intact and that you had mild to moderated degenerative disc disease. There was no disc herniation or abnormal alignment of the spine noted. While we acknowledge that you would not be able to perform a heavy occupation, the evidence presented within your file does not support a functional impairment that would preclude you from performing the material and substantial duties of your occupation as a Controller.

We are sorry that our ruling could not be more favorable, however, we must abide by the medical evidence and the policy provisions. You have exhausted all of your administrative remedies offered by the appeal committee and your file remains closed. This decision is final and binding.

Sincerely,

Doris Gloss RN A member of the Appeals Committee



PO 8ox 946710 Maitland FL 32794

Doris Gloss RN

Appeals Committee Member
Telephone 800-303-9744 x6272
Facsimile 407-919-6403

June 25, 2002

Rural & Pend Oreille Telephone Company Attn: James Martell 704 W. Madison Ave. Glenns Ferry, ID 83623

Regarding: Chris Dennison Claim Number: 2395634 Policy Number: 83116494

Underwritten by: Continental Casualty Company

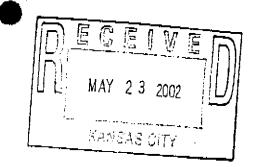
Service provided by: CNA Group Life Assurance Company

Dear Mr. Martell.

We have completed a comprehensive review of Mr. Dennison's claim file as he has requested in his appeal letter. The medical evidence presented does not support a functional impairment that would preclude Mr. Dennison from performing his occupation. Due to the confidential nature of Mr. Dennison's medical records, we are unable to provide you with a copy of his letter; therefore, this letter will serve to inform you that Appellate committee has upheld the denial.

Sincerely,

Doris Gloss RN Member of the Appeals Committee



May 2,2002

Mr. Brian Barnum "SENT VIA FEDERAL EXPRESS"
Disability Benefits Specialist
C.N.A. Insurance
P.O. Box 25939

RE: Appeal of C.N.A. declination of long-term disability benefits, Claim #2395634, Policy #83116494.

Dear Mr. Barnum:

Overland Park, KS 66225-5939

Attached is a letter from R. Tyler Frizzell MD regarding my physical condition and work limitations. Please reconsider my application for long-term disability benefits. Because of my physical limitations, I have not been able to work since February 1, 2002.

Additionally, there are two letters attached from Mr. Mike Richmond, dated March 8, 2002 and March 29, 2002, wherein he states that the Company considers my last day of employment with Rural Telephone Company March 6, 2002. In your letter dated March 15, 2002, you stated that on March 12, 2002 Mr. Richmond said they "will make any reasonable accommodations to accommodate his physical condition". I submit that this offer was without sincerity and contradictory, as evidenced by the date of Mr. Richmond's first letter dated March 8, 2002 and your telephone conversation with him on March 12, 2002. The Company effectively terminated my employment before your conversation with him.

If you have further questions or if there is anything I can do to accelerate the processing of this claim please call me at home, 208-658-0097. Time is of the essence because a delay will cause severe financial hardship. Thank you in advance for your consideration and assistance in this matter.

Best Regards,

Chris J. Dennison, CPA



DOUGLAS E. SMITH, M.D. CERTIFIED AMERICAN BOARD OF NEUROLOGICAL SURGERY

R. TYLER FRIZZELL, M.D., PH. D. CERTIFIED AMERICAN BOARD OF NEUROLOGICAL SURGERY

April 22, 2002

Re: Chris Dennison

TO WHOM IT MAY CONCERN:

Mr. Dennison is under my care for failed back syndrome and a history of lupus. He has had multiple surgeries and intractable back, neck, and leg pain.

It is my opinion that Mr. Dennison is disabled from these conditions and not able to engage in work of any kind.

Sincerely,

R. Tyler Frizzell, M.D.

R.TF/egs



March 29, 2002

Chris J. Dennison 9975 W. Hollingdale Dr. Boise, ID 83709

RE:

Final Pay Summary

Dear Chris:

Below is a summarization of events and outline of your severance from Rural Telephone Company:

Accrued Sick Balance Depleted (72 hrs):
Final 401k deduction/deposit:
Final payment to 401k loan (from payroll deduction):
February 27, 2002
February 27, 2002
February 27, 2002
March 6, 2002
March 6, 2002
NTCA Health Insurance valid through:
June 30, 2002*

As previously stated (March 8, 2002 letter), Rural Telephone Company will continue to pay your health insurance premiums through the second quarter, June 30,2002*. This date was shown as May 31, 2002 previously. We anticipate at this time, NTCA will be contacting you with COBRA information. In recognition of your service to the Company, Rural Telephone Company will pay the equivalent of 90-days regular pay to assist you during this time of transition from the workforce to a potential long-term disability status. Also, per your request, we have changed your exemptions to 9.

Enclosed you will find a check in the amount of \$10,058.99; which represents the balance of your lump sum severance package.

It is important to note that the final payroll deduction for your 401k loan payment was made on February 27, 2002. We suggest you contact Copper Mountain Trust in regard to your options and/or obligations with respect to this loan.

Sincerely.

Michael T. Richmond General Manager

Enclosure



March 8, 2002

Chris J. Dennison 9975 W. Hollingdale Dr. Boise, ID 83709

RE: Separation Notice

Dear Chris:

As of March 6, 2002, your accrued sick leave and 2002 earned vacation,time have been depleted and no additional hours are available. Therefore, Rural Telephone Company considers this as your final day of employment and will use March 6, 2002 as your separation/termination date from the Company.

As a courtesy, Rural Telephone Company will continue to pay your health insurance premiums through May 31, 2002. We anticipate at this time, NTCA will be contacting you with COBRA information. Your life insurance benefits are discontinued effective today and there will be no further 401k deductions/deposits.

Enclosed you will find a check in the amount of \$1,052.15; which represents the balance of eamed/used vacation time.

We are structuring a severance package and hope to meet with you sometime next week to discuss it.

Hope all is well with you. We look forward to visiting with you soon. If you have any questions in the meantime, please don't hesitate to contact me.

Sincerely,

Michael T. Richmond

General Manager

Enclosure

FAX TRANSMISSION

MEULEMAN & MILLER LLP

960 BROADWAY AVE., SUITE 400 POST OFFICE BOX 955 BOISE, IDAHO 83701 (208) 342-6066 FAX (208) 336-9712

FAX NUMBER 913-661-7777

TIME

TO:

Tabatha Kirke

FROM: Katherine W. Dennison

DATE: May 20, 2002

RE:

Chris J. Dennison, claim no.; 2395634, policy no.; 83116494

DOCUMENTS ATTACHED: Notes from Chris' file written by Dr. Frizzell and blood tests showing positive ANA results for Lupus.

MESSAGE: will fax an additional letter from Dr. Frizzell with further explanation regarding Chris' current medical condition. Thank you for your time this morning. I hope the Appeal Committee will understand how ill my husband is at this point in time. Also, I would hope that they would take under consideration the statement made by Mr. Richmond regarding accommodation as a false and malicious statement. He and Rural Telephone never had any intention of accommodation. At present, it is also a most point. Chris simply can not work, the Lupus has made him so ill that he must rest for most of each day. He also has so much back pain that he can not sit, he must lie down in bed or rest in his recliner. As I stated, this was a man who worked very hard, averaging 120 hours in a bi-monthly pay period. I am sure if one did a survey of the average hours worked by Controllers or CPA's that this is not out of the ordinary. He is very upset by the decline in his health, given a choice, of course, he would choose to work. He has no choice now.

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^{*} Including cover sheet.

IDAHO NEUROLOGICA-SURGERY, P.A.

DOUGLAS E. SMITH, M.D. CERTIFICA AMERICAN BOOKERS ON NELBEROLICA, SANCY

R. TYLER FRIZZELL, M.D., PH. D. CENTIFICATION ELIGIBLE AMERICAN BRIAND OF NEUROLUGICAL SHIRERY

April 22, 2002

Re: ChristDennison

TO WHOM IT MAY CONCERN:

Mr. Dennison is under my care for failed back syndrome and a history of lupus. He has had multiple surgeries and intractable back, neck, and leg pain.

It is my opinion that Mr. Dennison is disabled from these conditions and not able to engage in work of any kind.

Sincerely,

R. Tyler Frizzell, M.D.

R.TF/egs

Sent By: Idaha Neurological Surge PA; 208 344 1331;

May 20 - 0 2:29PM;

age a

2/7/02

CHRIS DENNISON

Mr. Dennison returns to clinic for follow-up of his neck and back pain.

His MRI shows some degenerative disc disease at L4-5 and L5-S1 with a mild protrusion and some degenerative changes in the cervical area. There is no surgical lesion.

We still has disabling back pain and is not able to work. This appears permanent, since he has had maximum medical therapy including multiple surgeries.

PLAN: I would like to see him a couple times a year to make sure there is no new surgical problem. He will follow-up with Dr. MacCarter.

R.TF/egs

R. TYLER FRIZZELL, M.D.

cc: Daryl K. MacCarter, M.D.

May 20 - (2:29PM; Sant By: Idahn Neurological Surge PA; 208 344 1331; May-20-6 Page 4/6 Page 1/1

> ST. LOW S MERIDIAN MEDICAL CENTER DEPARTMENT OF PATHOLOGY 520 S. EAGLE RD, MERIDIAN, ID 83642

20P

DENNISON, CHRIS J DOB: 10/09/1950 SEX: M

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END OF REPORT

** PERFORMING LAB: M ST. LUKE'S REGIONAL MEDICAL CENTER MRI ST. LUKE'S MERIDIAN MEDICAL CENTER

DENNISON, CORTS J 04/30/2002 16:11

PAGE 1

MAY-20-2002 MON 01:58 PM MEULEMAN & MILLER

FAX NO. 2083369712

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k Luka'o Madigal 208.381.4357

May - 20 -L 2:29PM: foice; [4]

Page 5/6 Page 1/1

ST. LUKE'S MERIDIAN MEDICAL CENTER DEPARTMENT OF PATHOLOGY 520 S. BAGLE RD, MERIDIAN, ID 83642

20F DENNISON, CHRIS J 10/09/1950 and SEX: H MR#1 542615 22659338

PHYSICIAN: 630 PRIZZELL,R. TYLER 222 N 2ND 5T SUITE 307 BOISE, ID 83702

H14918

COLLECTED: 03/21/2002 15:07

ANA SCREEN

ANTI-NUCLEAR AD

POSITIVE

**PL: M

Reference range: NEGATIVE

Pour performed at Quest Diagnostics Incorporated, San Juan Capistrano, California.

ANA, TITER & PATTERN ANTI-NUCLEAR AB TITER

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**PL: M

Reference range: <40

Unit: Titer HOMOGENEOUS

ANA PATTERN

Test performed at Quest Diagnostics Incorporated, San Juan Capistrano, California.

A positive ANA result may be seen in a variety of diseases and healthy individuals. Its interpretation depends on clinical findings and other laboratory data.

END OF REPORT

ST. LUKE'S REGIONAL MEDICAL CENTER ** PERFORMING LAB: M MR1 ET. LUKE'S MERIDIAN MEDICAL CENTER

DENNISON), CHAIS J 0\$/26/2\$02 10:0G

PAGE 1

MAY-20-2002 MON 01:58 PM MEULEMAN & MILLER

FAX NO. 2083369712

P. 06

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May - 20 - 9 4: 297M;

Page 6/6 lica) [1] Paga 1/1

ST. DENE'S MERIDIAN MEDICAL CENTER DEPARTMENT OF PATHOLOGY 520 S. FAGLE RD, MERIDIAN, ID 83642

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DEMNISON, CHRIS J DOB: 10/09/1950 SEX: H 22659338 MR4: 542615

FHYSICIAN; 630 FRIZZELL, R. TYLER 222 N 2ND ST SUITE 307 BOISE, ID 83702

H14910

COLLECTED: 03/21/2002 15:07

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[0-20]

NM/HR

**P1: M

END OF REPORT ** PERFORMING LAB: H ST. LUKE'S REGIONAL MEDICAL CENTER MR1 ST. LUKE'S MERIDIAN MEDICAL CENTER

DENNISON, CHRIS J 03/22/2002 04:38

PAGE 1

FAX TRANSMISSION CITRIS J. & KATHERINE W. DENNISON

9975 WEST HOLLANDALE DRIVE BOISE, IDAHO 83709 (208) 658-0097

FAX (208) 658-0097(call in advance) E-mail: katuchrisd@msu.com

PAGES*

FAX NUMBER

TIME

TO: Nancy Deskins

C.N.A. Appeals Committee

2

407-919-6574

FROM:

Katherine W. Dennison

DATE:

June 10, 2002

RE: Cheis J. Dennison, claim no.: 2395634, policy no.83116494

Documents: Letter via e-mail from Mike Richmond, Rural Telephone Co.

Message: Attached is an e-mail from Mike Richmond, Assistant General Manager for Rural Telephone Company. After repeated requests from me for a clarification of Chris' employment status, we received the attached e-mail. I remain at this point in total confusion as to Mr. Richmond's March 12, 2002 statement to C.N.A regarding "reasonable accommodation". As I have pointed out, that statement by Richmond was malicious in nature and intended to harm Chris. Again, there was never an intention on his part or Rural Telephone's to accommodate anything. Further, they could not have accommodated him even if their intention was to help Chris. Perhaps now a true picture of the nature of this individual is clarified.

I must also add that until September 2001 his career (Richmond's) consisted of selling insurance. Chris and I have managed businesses for over 20 years and both have B.S. degrees in Business Administration from a very good business college. We both have had extensive training in business as well as human resources and understand the fiduciary duty that we have to our employers with regard to actions and statements we make on behalf of that employer. Obviously, M. Richmond needs to have a more clear understanding of his duties to his employer.

I faxed to you on May 31, 2002 a letter from Dr. Frizzell stating that Chris could not work. Would you please call me to confirm your receipt of that fax at 208-342-6066.

I will also add once again - my husband is a very ill man. If he were give a choice, he would work. He can not, I thank you in advance for your immediate response, time is of the essence.

4 Including cover sheet.

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Dear Chris,

This letter follows your request for reconfirmation of your employment status. I will forward copies of my correspondence of March 8 and 29, 2002, to you, along with the original of this communication. As I advised you on March 8 and again on March 29, I understand that your employment terminated effective March 6, 2002, when you used up your accrued sick leave and vacation time.

Sincerely,

Michael T. Richmond General Manager



FAX TRANSMISSION

CHRIS J. & KATHERINE W. DENNISON

9975 WEST HOLLANDALE DRIVE BOISE, IDAHO 83709 (208) 658-0097 FAX (208) 658-0097(call in advance) E-mail: katnchrisd@msn.com

PAGES*

FAX NUMBER

407-919-6574

TIME

TO: Nancy Deskins

C.N.A. Appeals Committee

FROM: Katherine W. Dennison

DATE:

RE: Chris J. Dennison, claim no.: 2395634, policy no.83116494

Documents Attached: A letter from Dr. R. Tyler Frizzell dated

Message: Attached is a letter from Dr. Frizzell regarding my husband's health. I am handling the appeal process because of the gravity of his illness. I hope this assists in a positive and speedy result of the appeal. I also want to emphasis not only is my husband very ill but I have Multiple Sclerosis: I am the accounting manager for a very busy law firm. I am the sole caregiver for my husband. The additional stress created by the entire situation is having a negative affect on my health. Again, I thank you in advance for your immediate response, time is of the essence.

CONFIDENTIALITY NOTICE

THE INFORMATION CONTAINED IN THIS FACSIMILE IS CONFIDENTIAL INFORMATION OR ATTORNEY WORK PRODUCT OR BOTH AND IS FOR THE EXCLUSIVE USE OF THE INTENDED RECIPIENT LISTED ABOVE. ANY READING, DISCLOSURE, USE OR REPRODUCTION OF THIS COMMUNICATION OTHER THAN BY THE INTENDED RECIPIENT IS PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLASSE NOTIFY US BY COLLECT TELEPHONE CALL IMMEDIATELY AND RETURN THE COMMUNICATION TO US VIA UNITED STATES MAIL.

^{*} Including cover sheet.



DOUGLAS E. SMITH, M.D.

R. TYLER FRIZZELL, M.D., PH. D. CENTRICATION ELIGIBLE AMERICAN BOARD OF NEUROLOGICAL SUNCERN

May 21, 2002

Re: Chris Dennison

TO WHOM IT MAY CONCERN:

Mr. Dennison has been under my care for low back and cervical neck surgeries. The patient is disabled from his spine condition and is not able to work. He is not able to work with accommodations. The patient also has rheumatological disease with positive lupus studies.

Sincerely,

R. Tyler Frizzell, M.D.

R.TF/egs

AND THE STATE OF T

CLAIM ANALYSIS RECORD

Claimant: Chris Denvison Claim Number: 1395694	
3-14-01 Based or claimonts limitations placed by physicing,	_
employers ability to accommodate the already sedentary	
occupation of controller to the limitations, and modical inform	_
entitle there is a lack of medical information to	<u> </u>
Support a functional in pairment from performing the	
occupation of controller Will dery liability ponding	
secondary review Blanning	<u></u>
3-14-02 Claim being sent for team leader or supervisory signoff.	0.0
3-14-02 / Jaim vavirued - Marching Signation	<u> </u>
3-15-0+ Ktorian devilly lettors yent to EE+ ER. Blowning	\dashv
5-14-01 EE called to check a see if appeal received at said 10. To	77
IE + hat if he has constant and and received of said 110-10	10
vo problem. Barunn	\dashv
5-15-02 Rec'd file and copy of hequest for reconsideration, the	-
5-15-02 July need does not contain additional hierarca	
that after the original denial to 20 series. I	\exists ;
5-15.03 Peronsideration reviewed machack	
5-15-02 Letters sent. Think	\dashv
5-16-02 Claim forwarded to Appeal Styles	_
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	\dashv
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CLAIM ANALYSIS RECORD

Claimant C 1/7/3 Jenn/302 Claim Number 222	Claimant Chris Dennison	Claim Number	2395634112
--	-------------------------	--------------	------------

		ı
2/27/02	Reva claim for LTD processing / Early notice	ı
	Claim - fele transfersa to KC for continued	
	processing - Alken_	
2/20/02	File rec'd in Ha. Assigned to Brian	
-		
3-701	Called ER & completed Ex interview see enclosed. Blue	
3-7-01	1 1/2 1 11 /2 1 5 () - + (08-366-)(11/2) () 1 1/2 1	
3-(2-0)	Called Mike Richmond at 208-366-3614 and asked about	
	possible accomposations. He stated thexwill make any	
	reasonable accommodations to acommodate his physical	
<u> </u>	lcondition. Sit/Stord et will is not a problem Mike stated	
	all he knows is + hat Chris has suffered a back	
	covertion & Barning	
03/14/02	MCAL FROM a 1 of file Cours on a 1 feature as a 1	
00/14/02		
	lumber x-rays and MRI of entire spine, there is lack of	
	medical information to support a functional impairment	
	octivities = a sit stand option - Therestory	ρ.
	activities = a sit stand option - Jung kreyborn	DHIM
·		



P.O. Box 25939 Overland Park, K\$ 66225-5939 Tabatha Kirke Disability Benefits Specialist Telephone 1-800-303-9744 ext 5860 Fax 913-661-7777

May 15, 2002

Chris Dennison 9975 W Hollandale Drive Boise, ID 83709

Claim No: 2395634 Policy No: 83116494

Underwritten by Continental Casualty Company Services provided by CNA Group Life Assurance Company

Dear Mr. Dennison:

We have received your letter dated May 2, 2002 requesting that we reconsider our decision to deny future benefits on your claim. Along with your letter requesting reconsideration, we received a copy of a letter from your doctor and one from your employer to you regarding your final pay summary.

The letter we received from your doctor does not provide additional medical documentation that would change our decision of 3/15/02.

Because our decision to deny future benefits has not changed, your claim is being forwarded to the Appeals Committee. The Appeals Committee will advise you of their decision within 45 days of receipt of your recent letter. The Committee will notify you in writing if additional time will be required.

Sincerely,

Tabatha Kirke

Disability Specialist

Cc:

James Martell

khatta Kuhi

Rural & Pend Oreille Telephone Co.

704 W Madison Ave Glenns Ferry, ID 83623

Kirke, Tabatha D.

From:

Barnum, Brian K.

Sent:

Wednesday, May 15, 2002 12:25 PM

To:

Kirke, Tabatha D.

Subject:

FW: Copies of original appeal letters, E-Mail 1 of 3

original leter of appeal. EE claims to have sent this information on 5/6/02 and someone signed for it. I never received anything & told him his appeal will be handled from the 5/14/02 receipt date. He verified that he sent 3 two page faxes yesterday and the beloe letter which consists of his entire appeal. Will bring file to you.

---Original Message-From: C

Chris DENNISON [SMTP:katnchrisd@msn.com]
Tuesday, May 14, 2002 4;34 PM
brian.barhum@cna.com

Sent: To: Subject:

Copies of original appeal letters, E-Mail 1 of 3

Brian,

The files would not E-Mail all at one time, the rest are to follow.

Thanks for your help.

ÇNAAppealLir.do¢

Chris

May 2,2002

"SENT VIA FEDERAL EXPRESS"

Mr. Brian Barnum
Disability Benefits Specialist
C.N.A. Insurance
P.O. Box 25939
Overland Park, KS 66225-5939

RE: Appeal of C.N.A. declination of long-term disability benefits, Claim #2395634, Policy #83116494.

Dear Mr. Barnum:

Attached is a letter from R. Tyler Frizzell MD regarding my physical condition and work limitations. Please reconsider my application for long-term disability benefits. Because of my physical limitations, I have not been able to work since February 1, 2002.

Additionally, there are two letters attached from Mr. Mike Richmond, dated March 8, 2002 and March 29, 2002, wherein he states that the Company considers my last day of employment with Rural Telephone Company March 6, 2002. In your letter dated March 15, 2002, you stated that on March 12, 2002 Mr. Richmond said they "will make any reasonable accommodations to accommodate his physical condition". I submit that this offer was without sincerity and contradictory, as evidenced by the date of Mr. Richmond's first letter dated March 8, 2002 and your telephone conversation with him on March 12, 2002. The Company effectively terminated my employment before your conversation with him.

If you have further questions or if there is anything I can do to accelerate the processing of this claim please call me at home, 208-658-0097. Time is of the essence because a delay will cause severe financial hardship. Thank you in advance for your consideration and assistance in this matter.

Best Regards,

Chris J. Dennison, CPA



PhoneTools



Phone: 208-658-0097

Fax: 208-658-0097

Message:

Form Attached

From:

Chris J Dennison, CPA

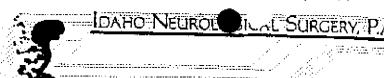
To: CNA Insurance

Mr Brian Barnum

000025

Date: 5/14/2002

Page(s): 2



DOUGLAS E. SMITH, M.D.

R. TYLER FRIZZELL, M.D. PH. D.

April 22, 2002

e: Chris Dennison

TO WHOM IT MAY CONCERN

Mr. Dennison is under my care for failed back syndrome and a history of Jupus. He has had multiple surgeries and intractable back, neck, and leg pain.

It is my opinion that Mr. Dennison is disabled from these conditions and not able to engage in work of any kind.

Sincerely,

NHX

R. Tyler Frizzell, M.D.

R TF/egs





Phone: 208-658-0097

Fax: 208-658-0097

Message:

Form Attached

From:

Chris J Dennison, CPA

To: CNA Insurance

Mr Brian Barnum

000027

Date:

5/14/2002

Page(s): 2

~ n =

704 W. MADISON

CLENNS FERRY, IDAHO \$3423

COMPANY (208) 366-2614 - PAX (208) 366-2615

March 29 2002

Chris J. Dennison 9975 W. Hollingdale Dr. Boise, ID 83709

Final Pay Summary

Dear Chris;

Below is a summarization of events and outline of your severance from Rural Telephone Company;

Accrued Sick Balance Depleted (72 hrs): Einal 401k deduction/deposit:

Final payment to 401k loan (from payrol deduction): Earned/Used Vacation Balance Depleted (120 hrs): Separation Date:

Life insurance discontinued:

NTCA Health Insurance valid through:

February 13, 2002

February 27, 2002

February 27, 2002

March 6, 2002.

March 6, 2002

March 6, 2002

June 30, 2002*

As previously stated (March 8, 2002 letter), Rural Telephone Company will continue to pay your health insurance premiums through the second quarter, June 30,2002. This date was shown as May 31, 2002 previously. We anticipate at this time, NTCA will be contacting you with COBRA information. In recognition of your service to the Company, Rural Telephone Company will pay the equivalent of 90days regular pay to assist you during this time of transition from the workforce to a potential long-term disability status. Also, per your request, we have changed your exemptions to 9

Enclosed you will find a check in the amount of \$10,058.99; which represents the balance of your lump

It is important to note that the final payroll deduction for your 401k loan payment was made on February 27, 2002. We suggest you contact Copper Mountain Trust in regard to your options and/or obligations

Sincerely

Michael T, Richmond

General Manager

Enclosure



PhoneTools



Phone: 208-658-0097

Fax: 208-658-0097

Message:

Form Attached

From:

Chris J Dennison, CPA

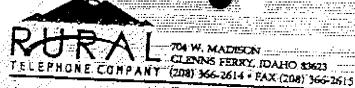
To: CNA Insurance

Mr Brian Barnum

000029

Date: 5/14/2002

Page(s): 2



March 8, 2002

Chris J. Dennison 9975 W. Hollingdale Dr. Boise, ID 83709

R٤

Separation Notice

Dear Chris:

As of March 8, 2002, your accrued sick leave and 2002 earned vacation time have been depleted and no additional hours are available. Therefore, Rural Telephone Company considers this as your final day of employment and will use March 6, 2002 as your separation/termination data from the Company.

As a courtesy, Rural Telephone Company will continue to pay your health insurance premiums through May 31, 2002. We anticipate at this time, NTCA will be contacting you with COBRA information. Your life insurance benefits are discontinued effective today and there will be no further 401k deductions/deposits.

Enclosed you will find a check in the amount of \$1,052.15; which represents the

We are structuring a severance package and hope to meet with you sometime next

Hope all is well with you. We look forward to visiting with you soon. If you have any questions in the meantime, please don't hesitate to contact me.

Sincerely.

Michael T. Richmond Gerieral Manager

Enclosure



P.O. Box 25939 Overland Park, KS 66225-5939 Brian Barnum Disability Benefits Specialist Telephone 1-800-303-9744 KC ext. 5862 Fax 913-661-7777

March 15, 2002

James Martell
Rural & Pend Oreille Telephone Co
704 W. Madison Ave
Glenns Ferry, ID 83623

Re:

Claimant:

Chris Dennison

Policy No.

83116494

Claim No.

2395634

Underwritten by Continental Casualty Company

Services provided by CNA Group Life Assurance Company

Dear Mr. Martell:

This is to advise you of the status of Mr. Dennison's Long Term Disability claim.

Based on a thorough review of the information in his file, we have denied his claim for benefits.

We are unable to provide you with specific information in accordance with state privacy laws. However, a detailed explanation of our decision and his appeal rights have been sent to Mr. Dennison.

Should you have any questions regarding this claim please feel free to contact me.

Sincerely,

Brian Barnum ALHC, AIAA, ACS

Disability Specialist



P.O. Box 25939 Overland Park, KS 66225-5939 Brian Barnum Disability Benefits Specialist Telephone 1-800-303-9744 Fax 913-661-7777

March 15, 2002

Chris Dennison 9975 W Hollandale Drive Boise, ID 83709

Claim #

2395634

Policy #

83116494

Underwritten by Continental Casualty Company

Services provided by CNA Group Life Assurance Company

Dear Mr. Dennison:

This letter will acknowledge receipt of your claim for Long Term Disability benefits.

Please refer to your policy under the section entitled "Occupation Qualifier" which states:

"Disability" means that during the elimination period and the following 24 months, injury or sickness causes physical or mental impairment to such a degree of severity that you are: 1. continuously unable to perform the material and substantial duties of your regular occupation; and 2. not working for wages in any occupation for which you are or become qualified by education, training or experience.

You are claiming disability due to back pain. A review of your claim was based on information contained in your file including medical information from Dr. Dallas Peck, Dr. Ralph Yeakley and Dr. R. Tyler Frizzell.

On the Physician's Statement completed by Dr. Frizzell under the section entitled "Physical Limitations" he states:

- No lifting, pushing or pulling over 5 pounds
- No prolonged standing or sitting
- Only occasional bending/twisting

On March 12, 2002 we contacted your employer who stated your occupation as a controller is strictly a sedentary job. Mike Richmond stated they "will make any reasonable accommodations to accommodate his physical condition." He also added that allowing a sit and stand at will option is not a problem.

To summarize, the only limitation given by Dr. Frizzell that would affect your occupation is no prolonged standing or sitting. As stated above, this limitation can be accommodated by your employer.

Therefore, based on information on file, there is a lack of medical information to support a functional impairment which would preclude you from performing the material and substantial duties of your occupation as a controller. Accordingly, we are unable to honor this claim for disability benefits.

If you disagree with our decision, you have the right to appeal under regulations specified by the Employee Retirement Income Security Act (ERISA) 1974 as amended.

If you have additional medical information not mentioned above or wish us to reconsider our decision, you should

- submit your formal request for reconsideration in writing to my attention within 180 days of the date of receipt of this letter
- addressed to

Attn: Brian Barnum Commercial Claims P. O. 8ox 25939 Overland Park, KS 66225

Include your claim number and policy number on any correspondence.

Our decision will be reconsidered at the time of receipt of your information. If this information does not alter our decision, you will be informed of this and your claim will then be submitted for a formal appeal review. A ruling will be issued within 45 days of receipt of your request for reconsideration as mandated by the Employee Retirement Income Security Act (ERISA) 1974 as amended. This regulation allows an additional 45 days to reach a decision if necessary, however you will be notified within the first 45 days if this review will require an extension of time to reach a decision. This decision will be in writing and mailed directly to you or your representative. You have the right to bring a civil action under §502(a) of ERISA following an adverse decision on appeal.

Appeals received later than 180 days may not be considered.

Should you have any questions in connection with your claim, please feel free to contact us.

Sincerely,

Brian Barnum ALHC, AIAA, ACS Disability Specialist

ER Interview for Chris Dennison

Called Susan Case and conducted ER interview for Chris Dennison on 3/7/02.

- 1. Verify the last day worked for Mr. Dennison? 2/7/02
- 2. Did Mr. Dennison miss any time prior to LDW for this injury? NO, not that I know of.
- 3. If so, what exact days did she miss?
- 4. Does Mr. Dennison have an estimated return to work date set? He told us, he does not have an anticipated RTW date.
- 5. Did Mr. Dennison have any work issues (ie, work history, upcoming events)? NO
- 6. What did Mr. Dennison's job consist of? Controller Prepared all of our spreadsheets, took care of all the correspondance with the federal & state agencies, accounting supervisor who had 3-4 people under him. Perform all the financial audits. He had a 2 and ½ to three hour commute total each day. Straight desk job.
- He mentioned he had to move boxes as part of his job. Was it part of the job? That
 is not necessarily part of his job, but we would have accommodated that if
 necessary.
- 8. Would you be able to accommodate a sit & stand option? I feel we would be able to, but Mike Richmond is the person to talk to there. He is out of the office right now, but I can have him call you in a couple of hours..
- 9. Verify Mr. Dennison's salary. \$73,542.00 divided by 26 weeks.



GROUP BENEFITS

2395634/12 D EMPLOYER'S STATEMENT

CNA Insurance Companies

FEB 19 2002

∌in

For All the Commitments You Make

FEB 1 5 2002 WILLO DU (OZ) INSTRUCTIONS TO EMPLOYER: Complete the Employed's Aprenent & attach job description. Instruct employee to complete Employee's Statement and have Physician's Statement completed. Mail the forms so that they <u>ARRIVE</u> at least 30 days before the end of the elimination period.

Name (Last, first, middle initial		Telephone No. (Inc	lude Area	(Code)	Date of Birth	1			
<u>Dennison, Chris J</u>		(208) <u>658</u>	<u>-0097</u>		10/09/50				
Address (Street number, city, sta	ate, zip code	·)							
9975 W Hollandale	XXX Dr	t, Boise, II	8370	9					
Date Employed 07/01/97	Effective 08/0	Date of LTD Covera	Ge	550 552-64-	-7849		Employee Cla	i	
Percentage of Employer Contrib	ution LT	D Premium paid wit	ד	Is the empl	oyee 's ∟ _5 co ∙	oczga c	cotinuous since	the l	
Toward Disability Premium: 1	<u> 20% ⊠</u>	Pre Tax 🔲 Pos	t Tax		ctive date? 🗔				
How is the employee paid? Hourly Salary Sa Commissions Only Ott	ter:		☐ We			onthly [Semi-Monthiy	,	
Basic Earnings as of last		regularly scheduled				Occup	ation		
	hours per v			e: 12/31			<u>troller</u>		
Duties: (include physical activities									
accounting for									
ledgers, on compu									
accountants, at	<u> </u>	. CONSULTAN	<u> </u>	<u>er augt</u>	<u>05, (a54</u>		es, gener	<u> </u>	
Date last worked prior to current	Has 6	Employee worked pa	rt-time or	partial duties	since disability	began?	Yes ᡚ N	6	
disability no zo zzoe		s, explain on reverse							
ls disability due to injury or sickr			Has emi	ployee retired	? □ Yes √ X		nployee termina	ted?	
employment? 🔲 Yes 🕒 No (If Yes, send	copy of Report of							
injury form.)			•	sput Date:	_//				
Workers' Compensation? ☐ Yes ∑XNo	Amount of I	Benelits Per	Date Benefits Began Date Benefits				enerīts Paid Thr	eugh	
Name and Address of Workers'									
Harrie Brid Admess of Working	oompenaan	on Garrier		l v	//C Claim #:				
1100							-		
				A	djuster:				
		. "							
				P	hone #:				
Please indicate any benefits you not be limited to company spon and / or bonuses. Sick Pay State Disabili	sored short	-term benefits. Stat	e disabilit	y benefits, si		continua	ince, commissi		
Amount d Benefits: \$	Per_	8_davs s	ick.	15 % davs	vacatio	ns 🤋	\$34.62 0	er hr	
Date Benefit Began					please list on b		** · · · · · · <u>c</u>		
02/04/02	90 1	_ ' \		•	des sick		acation		
Employer/Policy Holder's Name Rural & Pend Orei		pany paid Po	licy Numb	per	Telepho	ne Na. (I	nclude Area Co +2614	¢ €)	
Address (Street number, city, stat			783	311699	-L_		· 		
704 W Madison Ave	, Glenr	ıs Ferry, II	8302		<u> </u>		_		
อังกฤpleted By (Signature)		7 /	le		Deta			-	
Jones R Mas	<u> ZL</u>	<u></u>	RESID	ENT	3/	110	₹		

G-116298-C Online Version

 $\underset{000035}{\text{Revised 8/00}}$



PART A-STATEMENT OF EMPLOYER

Claims Customer Service: 1-800-303-9744

Continental Casualty Company (Disability)
Continental Assurance Company (Life)

Instructions:

- Complete the Employer's Statement
- Include Enrollment Form(s)/Beneficiary Designation(s)
- Attach Job Description including any physical demands
- If Worker's Compensation include Notice of Injury, Name of Carrier and Telephone Number
- If Accident include copy of Accident Report
- If Contributory (Employee paid) include Proof of Premium Deductions
- Instruct Employee to complete Employee's Statement and have Physician's Statement Completed
- · Mail the forms so that they arrive at least 30 days before the end of the LTD elimination period

Name of Policy Holder/Employer (as it appears on your policy):	Employee Name Chris J Dennison
& Pend Oreille Rural Telephone Companies	Social Security # 552-64-7849
	Status
Policy Number(s) Effective Dates(s)	□ Non-Exempt XX Salaried
	Monthly Salary 3 6.129
LTD# <u>\$R-83116494 08/01/99</u>	
Life #	Hourly Rate \$
LTD: Employer Contribution 100 % X Pre-Tax Post Tax	Effective Date of Reported Salary 12/31/01
Date of Hire <u>07/01/97</u>	Amount of Life Insurance:
Occupation Controller	Basic \$
XX Full-Time ☐ Part-Time	
No. of Hours Average btw 10-15 hours daily	Supplemental (if applicable) \$
Last actively at work date February 1, 2001	
Return to work date N/A	Voluntary (if applicable) \$
(if applicable) Termination Date N/A	Total \$
(if applicable)	
is Employee receiving any other weekly or monthly income?	☐ Yes XX No
Pension / Retirement - Date Started	Date Ended
Worker's Comp. Date Started	
STD (Short Term Disability) Date Started 8days Amounts, 15	dayservacetion @\$34 Date and r hour
Paid Sick Leave Date Started Eabruary 4, 2001 P	dus 67 days for company paid s/t disb
8 days sick leave. 3 weeks vacation	
Trustee or Employer Representative (Print or Type)	until t/T starts.
Address 704 W Madison Ave, Glenns Ferr	
Signature Jan R. Matel	Date 2/11/82
Phone (Ext.) 205-366-2614 Fax 208-366-261	

Position Description

Employee: Chris J. Dennison	Title: Controller
Office Location: Glenns Ferry	Department: Finance/Operations
Reports to: James R. Martell	

The overall objective of my department is:

To optimize company performance by enhancing operational and financial workmanship.

My major function is:

To plan, direct, coordinate and control the financial & accounting department. Assist with all lines of business, including subsidiary activities, by interpreting and implementing the objectives of the President and Board of Directors. Assist the President with Company management.

In order of importance, the principal responsibilities:

- To safeguard the Company's assets and fairly record Company liabilities by managing all
 accounting and financial operations, including: establishing operating procedures, Company
 policy, billing, receipts, disbursements, accounting and financial record keeping and reporting,
 budgeting and cash flow management, recommend and administer investments, and assist our
 outside accountants, attorneys and consultants in representing us to government regulatory
 agencies.
- 2. Assist in training managers and staff for greater productivity, accuracy and timeliness.

 To assist in scheduling and conducting annual staff performance reviews and recommend financial reviews when needed. To schedule, perform and submit my personal performance review annually, at my hire date anniversary.
- 3. Help determine new business and Company objectives. To daily administer internal operations.
- 4. To hold down expenditures and preserve the economic welfare of the Company. To preserve the confidential nature of the company's business and adhere to the highest ethical standards and loyalty when representing and dealing with the company, customers, other companies and other employees.
- 5. Meet with the management committee & Board of Directors as needed. To perform any other tasks and duties that may be permanently or temporarily assigned to me from time to time.

Agrand to: Onin Donnian	Date: (2/13/00
Approved by:	Date:

P. O. Box 25939, Overland Park, KS 66225-5939

2/19/02

Tabatha Kirke

Disability Specialist Commercial Accounts Claims

Telephone 913-661-5860 Facsimile 913-661-7777

FAX COVER SHEET

RECIPIENT'S NAME: Susan

COMPANY: Rural and Pend Oreille Telephone Co.

FAX ACCESS NUMBER: 208-366-2615

NUMBER OF PAGES: several

CLAIMANT NAME: Chris Dennison

CLAIM NUMBER: 2395634

Here is the info you requested. We will turn this into an LTD claim as your STD coverage was terminated effective 1/1/02.

Give me a call if this is wrong or you have any questions.

Tabatha Kirke



Short Term Disability Claim

#3395634

ABB + ABB

INSTRUCTIONS: Complete Part I of this form per Short Term Disability guidelines. When forwarding the form to your employee, include a self-eddressed envelope. If you have any questions regarding completion of this form, please contact the CNA Claim Processing Center at 1-800-303-9744.

Mo- 15 - Elected	griphe i like W		Er Erromann Sight	10.00				
Employer's Name	4112		Policy Number					
<u>Pural/Telephone Co</u>		1	SR-48311	16551)	·			
	25a	Date of Hire	Effective Date of Cov		imployer Contribution:			
Glenns Ferry, ID.		07/01/97	01 <u>/0</u> 1/2 <u>000</u>	<u>. 1.</u>	<u>? A ∩</u> % □ Pro-cox □ Post-cox			
Employee's Name			Occupation		· · · · · · · · · · · · · · · · · · ·			
Chris J Dennison :	•		Controll:	27				
Employee's Address			· <u> </u>		Employee's Phone Number			
9975 W Hollandale;D	r, Bois				1208-658-0097			
Date of Birth Social Secarity Number Salary Hourly Wage/Hours Worked Days Regularly Worked O/09/50 552-64-7849 \$73,542 annually USKIM IT WINTER								
Does job require lifting or carrying?	If yes, indi-	cate maximum amod	का अस्तिक स्टब्स कर्ना कर है।	n be lifted a	r antel:			
□ Y≅ □ No	50 po	unds						
Briefly describe employee's activities	including ma	jor physical demand	Si.					
accounting & billin	៤ និង១៩៦	visor, con	trol <u>ler, com</u>	<u>iouter</u>	<u>calculator</u>			
Nature of Disability	-			L: The a	Work Related Disability?			
Back Pain					Y-3			
Is simplayed receiving or entitled to receive other benefits? Yes N		yes, mellente the sour	ce and amount the emp	pl oyee is rec	eiving:			
Day Last Worked	Date Empl	oyec Expected to Rec	um to Work	Sick	Bank Paid Through			
1124112			 -	36	hours left			
Company Contact Name			Tide		Work Telephone Number			
James R Martell .		<u> </u>	<u>President</u>		208-386-2614			
Contact's Signature					Date			
		Un GOTTON			make your section is a section of the section of th			
Your attending physician should o	complete par	t III of this form.						
Delay in submitting this form could	d interrupt o	entinuation of your	benefit payment.					
I hereby authorize any physicia dates or information concerning representative.	n, hospital,	employer, insure	ır, or other organiz	ation or p sted by C	erson having any records, NA or their authorized			
EMPLOYEE SIGNATURE				Date				

* * * COMMONICATION RESULT REPORT (FEB. 19. 2002 3:03PM

TTI CNA GROUP BENEFITS

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E-2) BUSY E-4) NO FACRIMILE CONNECTION.



P. O. Box 25939, Overland Park, KS 66225-5939

2/19/02

Tabatha Kirke Disability Specialist Commercial Accounts Claims Telephone 913-861-5860 Facsimile 913-861-7777

FAX COVER SHEET

RECIPIENTS NAME: Susan

COMPANY: Rural and Pend Oreille Telephone Co.

FAX ACCESS NUMBER: 208-366-2615

NUMBER OF PAGES; several

CLAIMANT NAME: Chris Dennison

CLAIM NUMBER: 2395634

1.3.2005



76:050 201002

Short Term Disability Claim

#2395634

For All the Commitments Tou Make'

INSTRUCTIONS: Complete Part I of this form per Short Term Disability guidelines. When forwarding the form to your employee, include a self-addressed envelope. If you have any questions regarding completion of this form, please contact the CNA Claim Processing Center at 1-300-303-9744.

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February 8, 2002

Mr. Mark Crister CNA Group Benefits 1420 5th Avenue, Suite 2005 Seattle, Washington 98101

RE: Attached Long Term Disability Forms

Dear Mark:

Ms Trish Coba, from Seabury & Smith, instructed me to forward attached forms to you. Included are the online versions of:

◆ Form LD-1001-A: Group LTD and Life Waiver of Premium Claim Form

"SENT VIA FEDERAL EXPRESS" 43 Drag

- ◆ Form G-102063-A: Claimant's Job Activities Statement
- ◆ From G-116298-C: LTD Employer's Statement
- ◆ Form G-116299-B: LTD Employee's Statement
- ◆ Form G116300-C: Physician's Statement

I believe all of the forms are properly completed and signed, but since I have never prepared anything like this, I'll need your help. I appreciate any assistance that you may give. Trish requested that you call her when you receive the forms. Her telephone number is 208-338-6457.

You can reach me at either of the following numbers, home – 208-658-0097 and cell phone – 208-602-5791. I don't know if I can continue work with the present pain levels and medications, however, my work number is 208-366-2614.

Thanks in advance fro your help.

Best Regards,

Chris J. Dennison



927 W. MYRTLE ST. BOISE, IDAHO 83702 (208) 367-7510

www.idahoxtay.com

G. W. BROWN, MD C. H. COULAM, MD I, C. DAVEY, MD N. C. DAVEY, MD V. GARABEDIAN, MD R. J. GOBEL, MD J. T. HALL, MD

J. O. KNOCHEL, MD W. T. MURRAY, MD D. R. NEWTON, NO. D. D. PECK, MD L. M. SCALES, MD J. T. SEABOURN, MD P. D. TRAUGHBER, MD.

Patient: MR #:

DENNISON, CHRIS J.

374376

Visit #: 203504949

Date of Birth: 10/09/1950

Hosp, Serz.: DXT - ZZA Room/Bed:

Exam #:

P. Oate:

02/04/2002 759757

Diet. MD: DALLAS PECK, MD Reg. MD: R. TYLER FRIZZELL, MD

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Job Number: 714719

Version: 1

Page 1 of 2

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SCREENING MAGNETIC RESONANCE IMAGING STUDY OF THE ENTIRE SPINE WITHOUT AND WITH INTRAVENOUS GADOLINIUM, 2/4/2002

HISTORY. Back pain and severe left lower extremity pain.

TECHNIQUE: Please refer to the MRI prescription sheet for details. Intravenous gadolinium (20 cc) was administered as a part of this examination.

FINDINGS:

The patient developed nausea and vomited just after the intravenous administration of gadolinium. No other symptoms of allergic type reaction.

CERVICAL SPINE: The overall alignment of the cervical spine is maintained. The vertebral bodies at C5-6 appear to be fused anteriorly. No evidence of disk herniation, overall spinal canal stenosis of neural foraminal narrowing is identified. There are changes of degenerative disk disease at C4-5 and C6-7 with mild diffuse posterior disk bulges at these levels. The cervical cord maintains normal size, signal and shape throughout The craniocervical junction has normal appearance.

THORACIC SPINE: The normal alignment of the thoracic spine is maintained. Marrow signal is normal within the visualized bones. The thoracic cord is of normal size, signal and shape throughout. There are changes of mild degenerative disk disease within the mid thoracic spine which are most promident at T6-7 with mild diffuse disk bulge at this level without evidence of overall spinal canal stenosis or neural foraminal narrowing.

LUMBAR SPINE: The overall alignment of the lumbar spine is maintained. The conus is at the level of T12-L1. The visualized cord is of normal size, shape and signal. There are reactive marrow changes adjacent to the end plates at L4-5 and L5-S1.

- L1-2: There is relative disk desiccation and mild disk height loss without evidence of disk herniation, spinal canal stenosis or neural foraminal narrowing.
- L2-3: There is a circumferential disk bulge superimposed tiny posterior right paracentral disk protrusion without evidence of overall spinal canal stenosis of neural foraminal narrowing.

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Patient:

Visit #;

DENNISON, CHRIS J

374376 MP.#:

203504949

Date of Birth: 10/09/1950

Hosp, Serv.: DXT - ZZA

Room/Bed: P. Date:

Exam #:

02/04/2002

759757

LAS PECK, MO Olet, MÖ Req. MO: R. TYLER FRIZZELL, MO

Req. MD:

Job Number: 714719

Version: 1

Page 2 of 2

SCREENING MAGNETIC RESONANCE IMAGING STUDY OF THE ENTIRE SPINE WITHOUT AND WITH INTRAVENOUS GADOLINIUM, 2/4/2002

L4-5: There are postoperative changes from left hemilaminectomy and discertomy. A small amount of enhancing tissue is present within the left lateral recess compatible with scar or granulation tissue. No evidence of recurrent or residual disk herniation is identified. The neural foramina are widely patent bilaterally. There is no evidence of overall spinal canal stanosis at this level. There are moderate bilateral facet osteoarthritic changes.

L5-S1: There are changes of severe degenerative disk disease with disk desiccation and marked disk height loss. There is a small broad based posterior central disk protrusion which results in mild to moderate left lateral recess stenosis and possible mass effect on the traversing left S1 nerve root. There are postoperative changes from discectomy at this level in the past with small amount of scar or granulation tissue which enhances in the left lateral recess. No evidence of overall spinal canal stenosis or neural foraminal narrowing is identified at this level.

OPINION:

CHANGES OF MILD DEGENERATIVE DISK DISEASE WITHIN THE MID CERVICAL AND MID THORACIC SPINE AS DETAILED IN THE FULL REPORT, WITHOUT EVIDENCE OF DISK HERNIATION, SPINAL CANAL STENOSIS OR NEURAL FORAMINAL NARROWING. THERE ARE POSTOPERATIVE CHANGES FROM LEFT-SIDED HEMILAMINECTOMY AND DISCECTOMIES AT L4-5 AND L5-S1. AT L5-S1 THERE IS A SMALL BROAD BASED POSTERIOR CENTRAL DISK PROTRUSION WHICH RESULTS IN MILD TO MODERATE LEFT LATERAL RECESS STENOSIS. MORE MILD CHANGES OF DEGENERATIVE DISK DISEASE ARE PRESENT THROUGHOUT THE REMAINDER OF THE LUMBAR SPINE.

DP : ar

D/D: 02/05/2002 07:02 T/D: 02/05/2002 11:57

J# 714719 T#. 14069929

CC:

R. TYLER FRIZZELL, MD

DALLAS PECK, MD

BOISE RADIOLOGY GROUP, PA TODO S. JURT, MO CHARLES R. CARRASCO, MO ELANG M. DANIEL, MO RICHARD H. LANE, MO RETER A. LANGHUS, MO CRAIO S. LEYMASTER, MO STEVEN M. WARK, MO LANGE R. MAKWELL, MO RAY M. THORPE, MO RAY M. THORPE, MO

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BAX - ANDERSON PLAZA DIAGNOSTIC X-RAY

RALPH M. YEAKLEY, M.D.

NAME: Dennison, Chris J

DOB: 10/09/1950

ADM: 01/29/2002

DIS:

01/29/2002

BILLING NUMBER: 000022605549 MEDICAL RECORD NO.: 0542615

ROOM: - PT/SVC: O/AMI

DATE:01/29/2002

TWO VIEW LATERAL LUMBAR SPINE

CLINICAL DATA: Leg numbness. Tailbone pain.

COMPARISON EXAM: None.

FINDINGS: The dictation is based on the assumption that there are five lumbar-type vertebrae. Moderate L4-S1 disk degeneration with marginal hypertrophic spurring and loss of disk space height is present. There is milder T11-T12 and L1-L2 disk degeneration with some mild hypertrophic spurring. No spondylolysis or spondylolisthesis.

CONCLUSION: Mild thoracolumbar and moderate L4-S1 degenerative disk disease.

ELECTRONICALLY AUTHENTICATED RALPH M. YEAKLEY, M.D. Jan 31 2002 7:15A Boise Radiology Group

T: LDM

d: Jan 30 2002 5:08P t: Jan 30 2002 10:51P

Document #881528 Job # 22970

CC: R. TYLER FRIZZELL

Thu Jan 31 09:24:03 2002 St Luke's Medical 208.381.4357 (Voice) [0] Page 1/1

BOISE RADIOLOGY GROUP, PA TODO B. BURT. MO CHARLES R. GARRAGO, MO BLAIME M. GARREL, MO JETER A. LANGHUS. MO JETER A. LANGHUS. MO JENIG E. LETMASTER, MO STEVER V. MARK, MO JAMES R. WAKWELL, MO BRENT O. HELSON, MO RAY M. THORPS, MO



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BAX - ANDERSON PLAZA DIAGNOSTIC X-RAY

TODD B BURT, M.D.

NAME: Dennison, Chris J

DOB: 10/09/1950

ADM: 01/29/2002

7/2002 DIS:

01/29/2002

BILLING NUMBER: 000022605549 MEDICAL RECORD NO.: 0542615

ROOM: - PT/SVC: O/AMI

DATE:01/29/2002

TWO VIEW LATERAL CERVICAL SPINE

CLINICAL DATA: Prior neck surgery. Arm numbress and neck pain.

COMPARISON EXAM: None.

FINDINGS: Surgical changes of prior C5-C6 interbody fusion is present and appears to be solid. There is mild to moderate C4-C5 and moderate C6-C7 disk space narrowing with associated marginal hypertrophic spurring and disk space loss. The spine is in normal alignment. No fracture or subluxation. The prevertebral soft tissues are unremarkable.

CONCLUSION: 1) There is a solid-appearing C5-C6 fusion. 2) Mild to moderate C4-C5 and moderate C5-C6 disk degeneration.

ELECTRONICALLY AUTHENTICATED TODD B BURT, M.D. Jan 31 2002 9:26A Boise Radiology Group

T: LDM

d: Jan 30 2002 5:07P t: Jan 30 2002 10:53P

Document #831522 Job # 22976

CC: R. TYLER FRIZZELL

GROUP LTD AND LIFE WAIVER OF PREMIUM CLAIM FORM

CNA

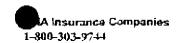
PART B - STATEMENT OF EMPLOYEE

Claims Customer Service: 1-800-303-9744 COMPLETE ALL INFORMATION & SIGN

Present Address (Siver number; giv. appe. to poole) Fors 97.5 Molise and all Dr. Bolse 1D 8370 Employer Name Part-Time Controller	Lost Name Dennison	First Name Chris	Middle James	Date of Birth S.S.# 10/09/50 552-64-	7849				
Date when you last reported for work 0.3./0.1./0.2 Date you returned or expect to return to work	Present Address (Street number, city, state, 19975 W Hollandalé Dr.	rip code) , Boise, ID 8370)9	Email katnohrisd	⊕msn.¢om				
Date when you last reported for work 0.3./0.1./0.2 Date you returned or expect to return to work	Telephone 208-658-0097	x Same, call firs	Employer Name t Rural Te						
Date of First Modical Treatment for this condition 0.1/29/0.2 Are you now engaged in the duties of any occupation or endeavor for wages, profit or compensation? West ENDo Explain: Was an accident involved? Yest Mo If yes, how did the accident occur? Were you at work when it happened? Yest No If motor whicle, accident areach copy of the Police Accident Report. Are you receiving or have you applied for any benefits, earnings or income other than those provided by your Employer? Yest ENDo If yes, please provide the name(s), address, phone number(s) of all companies providing disability benefits: Date Benefits began Dated ended Martial Status Single Envarmed Universed Widowed List names and burth dates of spouse and all dependent children Katherine W Dennison **AUTHORIZATION** Upon presentation of the original or photocopy of this signed authorization, I authorize any medical professional, hospital or other medical—are institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Continental Assurance Company/Continental Casualty Company or an agent, authorize, group policyholder or benefit plan administrator to provide Continental Assurance Company/Continental Casualty Company with financial or employaer or decased or benefit plan administrator to provide Continental Assurance Company/Continental Casualty Company with financial or employeer of independent administrator to provide Continental Assurance Company/Continental Casualty Company with financial or employeer or independent administrator to provide Continental Assurance Company/Continental Casualty Company with financial or employeer or independent administrator to provide Continental Assurance Company/Continental Casualty Company with financial or employeer or continents and administrator to provide Continental Assurance Company/Continental Casualty Company to Social Security Number 55 2 – 54 – 784 9 It is information in classification to the p	l Output vista / Luk Tiela		XX Full-Time	l Part-Time					
Are you now engaged in the duties of any occupation or endeavor for wages, profit or compensation? Was an accident involved? Yes LyNo If yes, how did the accident occur? Were you at work when it happened? Yes No If motor which the happened? Yes No If we pholic sections areast opport of the Police Accident Report. Are you receiving or have you applied for any benefits, earnings or income other than those provided by your Employer? Yes LyNo If yes, please provide the numels), address, phone number(s) of all companies providing disability benefits: Dated ended Martial Status I Single LyMarried LyDivorced LyWidowed List names and birth dates of spouse and all dependent children Katherine W Dennison "AUTHORIZATION" Upon presentation of the original or photocopy of this signed authorization, lauthorize any nactical professional, hospital or other medical-care institution, incurance support organization, pharmacy, governmental agency, instituted agency, instituted to provide Continental Assurance Company, group policyholder, employer or benefit plan administrator to provide Continental Assurance Company or use of alcohol. I also authorize my employer, group policyholder or benefit plan diministrator, and administrator to provide Continental Assurance Company or use of alcohol. I also authorize my employer, group policyholder or benefit plan diministrator to provide Continental Assurance Company (Continental Casality Company or an agent, attorized and information. I also hereby authorize the Social Security Authorize the Social Security Authorize the Social Security Authorize the Social Security Authorize to Casality Company benefits. Policy Benefits, Policy	Date when you last reported for work 👝 🦯	O 1 / O 2 Date you return	ed or expect to retium t	o work					
Was an accident involved? If yes In your lives, how did the accident occur? Were you at work when it happenel? If yes No If yes, how did the accident occur? Were you at work when it happenel? If yes No If yes, how did the accident occur? Were you the work when it happenel? If yes No If yes, please provide the name(s), address, phone number(s) of all companies providing disability benefits: Date Benefits began Dated emded International Date of the Police Accident Report. Marial Status I Single Limarried II Divorced I Widowed List names and birth dates of spouse and all dependent children. Katherine W Dennison. **AUTHORIZATION** Upon presentation of the original or photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Continental Assurance Company/Continental Casualty Company or an agent, astrony, consumer reputing agency of independent administrator to provide Continental Assurance Company/Continental Casualty Company with financial comployment related information. I also hereby authorize the Social Security Administration to send a copy of the Award (including information Electronic Continental Assurance Company/Continental Casualty Company or a large of including information is required by Continental Assurance Company/Continental Casualty Company or occupant, strong, conjugorement related information. I also hereby authorize the Social Security Administration to send a copy of the Award (including informatic strong the purpose of evaluating my company or an agent (including informatic strong the purpose of evaluating my company or occupant (including informatic strong to relate the formation is required by Continental Assurance Company (Continental Assurance Company Continental Assurance Company Continental Assurance Company (Continental Assurance Company Continental Assurance Company	Date of First Medical Treatment for this con-	dition 01/29/02		·					
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If motor vehicle accident attach oppor of the Police Accident Report. Are you recruining or have you penied for any benefits, carnings or income other than those provided by your Employer? Are you recruining or have you benefits. Dated emded	Was an accident involved? L. Yes Ly No If yes, how did the accident occur?								
Are you receiving or have you applied for any benefits, earnings or income other than those provided by your Employer? Yes No If yes, please provide the name(s), address, phone number(s) of all companies providing disability benefits: Dated ended Martial Status Single Married Divorced Widowod List names and birth dates of spouse and all dependent children Katherine W Dennison	If more vehicle accident attach copy of the l	Police Accident Report.							
Upon presentation of the original or photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Continental Assurance Company/Continental Casualty Company or an agent, attorney, consumer reporting agency or independent administrator, acting on his behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employee, group policyholder or benefit plan administrator to provide Continental Assurance Company/Continental Casualty Company with financial or employment related information. I also hereby authorize the Social Security Administration to send a copy of the Award (including family awards, if any) or Disallowance Notice to CNA Group Benefits, PO Box 946710, Maittand, Florida 32794-6710 for Social Security Number: \$5.2 – 64.784.9 This information is required by CNA): [I understand that such information will be used by Continental Assurance Company/Continental Casualty Company to calculate my disability benefits under Claim Number (to be completed by CNA): [I understand that such information will be used by Continental Assurance Company (Continental Casualty Company for the purpose of evaluating my claim for insurance benefits and that on any authorization will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim. I agree that a photographic copy of this authorization shall be as valid as the original. I know it is a crime to complete this form with information I know is false or to omit any facts. I know are important. Signature [I understand the authorization who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim con a pop	Are you receiving or have you applied for an	ny benefits, earnings or income o	ther than those provide rt(s) of all companies p	d by your Employer? roviding disability benefits:					
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Residents of all states EXCEPT FL, NJ, AZ: Any person who knowingly and with the intent to defraud any insurance company or other person tiles an application for insurance or settlement of claim containing any materially false information or concerning for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. FLORIDA RESIDENTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. NJ RESIDENTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. ARIZONA RESIDENTS: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. I have read and I understand the above notice. Signature Date Date Date	institution, insurance support organization, padministrator to provide Continental Assurant independent administrator, acting on his behavior and below, including information relating or benefit plan administrator to provide Continformation. I also hereby authorize the Soci Disallowance Notice to CNA Group Benefits This information is required by Continental Anumber (to be completed by CNA): //Continental Casualty Company for the purport of the purport of the purport of the purport of the complete opposition of the purport of the purport of the complete of the purport of the purport of the complete of the purport	by of this signed authorization, I harmacy, governmental agency, and Company/Continental Casual alf, information concerning advicto mental illness, use of drugs of inental Assurance Company/Contial Security Administration to see, PO Box 946710, Maitland, Flassurance Company/Continental	authorize any medical insurance company, graity Company or an ager ite, care or treatment progress, care or treatment progress, care of alcohol. I also minental Casualty Commod a copy of the Award orida 32794-6710 for S Casualty Company to essuch information will issurance benefits and the from the date signed to low it is a crime to comp	oup policyholder, employer or benefit, attorney, consumer reporting agenovided the patient, employee or decea authorize my employer, group policypany with financial or employment to (including family awards, if any) or ocial Security Number: $5.5.2-6.4$ -talculate my disability benefits under be used by Continental Assurance Coat I or any authorized representative in the duration of the claim. I agree the letter this form with information I knowledge.	t plan cy or ised yholder elated - 7849 t Claim ompany will at a				
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	I have read and I understand the above no	tice.		1 /					
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← FILL OUT TOP PORTION OF PHYSICIAN'S STATEMENT ON PAGE 3







For All the Commitments You Make*

Company Name

Rural Telephone Company

* SEE ATTACHED SUPPLEMENTAL STATEMENT

	Name (Last, first, middle initial)			Telephone No. (Inch	ide Area Code)	D	ate of Sinth	
	Dennison, Chris J.		-	<u> 208-658-00</u>	97		<u> 10/09/</u>	
	Home Address (Street number, city, state, 2	ip code)					cunty Numbe	
	9975 W Hollandale Dr					552 <u>-</u> 6	<u>4-7849</u>	
	Mailing Address, if different from Home Addr	ness(Stre	et number, city	r, state, zip code)				
	9975 W. Hoplandale D	e, B	<u>oise, I</u>	<u>D 83709</u>			,	
	Marital Status:	र्म क	amed, Spcuse	's Name & Birth Date	Number of De	ependent	Birth Date	of Youngest
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j	c. State Disability Insurance				1			
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	d. Retirement or Pension							<u> </u>
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- {	deceased named below, including infi	ormation	relating to	mental illness, use	of drugs or u	se of alcoh	ol. I also	authorize my
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G-116299-8 - Online Version

Revised 8/00

Page 1 of Z 000048

Chris J. Dennison, 552-64-7849 Rural and Pend Oreille Telephone Companies Policy SR-83116494 Form G-116299-B-Online Version, LTD Employee's Statement February 5, 2002

From April 1998 through April 1999 I underwent 5 back surgeries to alleviate continuous extreme pain in both my neck and lower back. At that time through April 2001 I believed that the problems were cured.

Beginning in April 2001 through today the pain has progressed in frequency, duration and intensity. I attempted to get by with over-the-counter pain medications. During this time and up to January 29, 2001 I was working between 60 to 80 hours a week. Two weeks ago the pain became so intense I returned to see R. Tyler Frizzell M.D. Ph.D., on January 29, 2001, about the problem. He requested both an X-ray and an M.R.I. and prescribed pain medication. I could not carry on with my job duties with the amount of pain I was experiencing. I could not, and still can't, stand or sit-up for longer than 10 to 15 minutes without shaking from the pain. My arms and legs become numb and lose feeling. When I attempt to stand up from sitting I initially lose my balance. I have no feeling in my fingertips and toes. The pain from my neck causes migraine headaches, causing an additional impediment to performing my job duties. I couldn't, and still can't, function while performing my job obligations because of the pain.

My last day of work was February I, 2001. I don't believe I can continue within the scope of my job responsibilities or any duties until the pain subsides. My understanding is that medication will help but not cure the problem. My type of work requires a lucid mind that cannot exist while under the influence of drugs. I can't lift, I can't sit, I can't stand and I can't think well when taking the required medications or with a migraine headache.

Dr. Frizzell indicated, from the tests, three different places in my spine and neck that are causing the pain. We discussed treatment and a prognosis. From the discussion, long-term disability appears to be the only way to allow me the ability to alleviate the deterioration in my spine and some of the related pain. If I continue with my present job requirements the problem will only get worse.

My wife has Multiple Sclerosis and is progressively unable to maintain our household. I am not able to help her or "take-up-the-slack" because of pain and related lack of energy.

I approach long-term disability with trepidation because I enjoy my career and do not wish to stop working. Saying that, I can no longer live with the pain or the collateral incapacities.

Page 2 of 2



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RURAL TELEPHONE COMPANY Position Description

Employee: Chris J. Dennison	Title: Controller
Office Location: Glenns Ferry	Department: Finance/Operations

Reports to: James R. Martell

The overall objective of my department is:

To optimize company performance by enhancing operational and financial workmanship.

My major function is:

To plan, direct, coordinate and control the financial & accounting department. Assist with all lines of business, including subsidiary activities, by interpreting and implementing the objectives of the President and Board of Directors. Assist the President with Company management.

In order of importance, the principal responsibilities:

- To safeguard the Company's assets and fairly record Company liabilities by managing all
 accounting and financial operations, including: establishing operating procedures, Company
 policy, billing, receipts, disbursements, accounting and financial record keeping and reporting,
 budgeting and cash flow management, recommend and administer investments, and assist our
 outside accountants, attorneys and consultants in representing us to government regulatory
 agencies.
- 2. Assist in training managers and staff for greater productivity, accuracy and timeliness.

 To assist in scheduling and conducting annual staff performance reviews and recommend financial reviews when needed. To schedule, perform and submit my personal performance review annually, at my hire date anniversary.
- 3. Help determine new business and Company objectives. To daily administer internal operations.
- 4. To hold down expenditures and preserve the economic welfare of the Company. To preserve the confidential nature of the company's business and adhere to the highest ethical standards and loyalty when representing and dealing with the company, customers, other companies and other employees.
- 5. Meet with the management committee & Board of Directors as needed. To perform any other tasks and duties that may be permanently or temporarily assigned to me from time to time.

Agreed to: (him) Commission	Date: (2/13/80
Approved by:	Date:
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FORM LW28				to the Internal Revenue Service	by a To be riled with employee's FEDERAL Tax Return. Information is being furnished to the Internal Revenue Service.
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thineid	6 Medicare lax withheld	Medicare wages and tips	Q	AVE.	704 W. MADISON
4485.20	44	72342.00		COMPANY	ELEPHONE
ex withheld	4 Social security tax withheld	Social si	3	code	Employer's name, address, and ZIP code
1321,90	1137	68058.00			930739703
tax withheld	2 Federal income tax withheld	Wages, tips, other compensation			Employer Identification number
et www.ins.gov.	•	FASTI Une PER TILE	OMB No. 1545-0008		63
70 1111 211		0212 21211111			Control number



PHYSICIAN'S STATEMENT

For All the Commitments You Make* PLEASE PRINT – Use a separ	ate sheet of paper to answer questions		
where space does not permit.	· · · · · · · · · · · · · · · · · · ·		
Patient's Name Chris J Bennison	Date of Birth 10/09/50		
Patient's Address – Street, City, State, Zip Code	Fhone Number (Area Code First)		
9975 W Hollandale Dr. Boise, 10 83709 Employers Name	223-658-0097 Policy Number		
Rural Telephone Company	SR-83116494		
I hereby authorize release of information on this form , by the physician name on	/ /		
for the purpose of claim processing. Signature	Date: 02/07/07		
1. HISTORY			
Progre	ssively from 04/01 to date		
(a) When did symptoms first appear or accident happen? Month	T Day Year		
	001 Day <u>29 Year_02</u>		
	Day Year		
(d) Has patient ever had same or similar condition?	s □No		
it yes, please state when and describe.			
(a) to condition due to injury or pightages existing out of policytic ampleys	mont? [] Vos [] No [] Hekrown		
(e) is condition due to injury or sickness arising out of patient's employ	Melit: (2) 163 (2) (4) (2) (3) (4)		
2. MEDICAL CONDITION			
(a) Diagnosis: Jumbago Z Status Pos			
(b) Complications: dismostrant necle à brille	pain from multiple		
(c) symptoms: 5 ignificant Drg. charges in Lamber spins a nurreluing			
i (d) OBJECTIVE FINDINGS (Please attach reports including x-rays, EK	(G's, Lab Data and any clinical findings):		
+ Schoening Spino mn= 2/4/-2			
,			
	•		
3. NATURE OF TREATMENT			
(a) What are the treatment plans? Micds ് വേട്ടാവം 🕂 വര	· transforment		
(b) Surgery: No further Surgery			
(c) Medications: ン、でとせいへ			
(d) Has this person been referred to another physician? 日Yes 日代 Name and address of this physician:	lo		

(e) Date of last visit: Month ______ Day ______ Year ________

(f) Is further treatment required? For which would perfect the followings

A DINGIGAL LIBERTATIONS		· · · · · · · · · · · · · · · · · · ·
4. PHYSICAL LIMITATIONS What are the specific limitations (i.e., lifting, sta	ndina stannina)	
wo lifting, pushing o.		
No prolonged stant:	ng or sitting	,
Only occasional bends	ny/turisting	
	, ,	
	□ V	
5. Does this person have mental or nervous limitations? If yes, please describe:	☐ Yes 6 Mer	
	·	
5. PROGNOSIS (Recovery and return to work date)		
700r		
Condition is Chronic =	has re-gressed	oner time
Chronic pain in Lumb		
44,000	•	
REMARKS:		» 11
December of Pts. Multi.	al. Spine Surge	vies
developed degenerative	changes as well	
Can Guly offer Conse Jain management -	ructive trendme	end for
fair management -	ne further Jui	rdend 6
this time-	·	,
Name (Physician) Please Print	Specialty	Telephone
R Tyler Frizzell M.D.Ph.D.	Newyor Surgeon	208) 344-1000
Address - Street, City or Town, State or Province, Zip Code 222 North Second Street, Suite 307	, Boise, ID 83702	
Signature A		Date / / _
1 × /1.1.~ /1.~.		/ / / / / / /

For information regarding where to mail this form, contact your Human Resource Representative, Benefits Administrator, or CNA Group Benefits Sales Representative.

GROUP LTD AND LIFE WAIVER OF PREMIUM CLAIM FORM



PART C - ATTENDING PHYSICIAN'S STATEMENT

EMPLOYEE: COMPLETE TOP PORTION AND SIGN BEFORE SENDING TO PHYSICIAN.

Patient's Name:	Date of Birth
Chris J Dennison	10/09/50
Parient's Address - Street, City, State, Zip Code	Phone Number (Area Code First)
9975 W Hollandale Dr. Roise, ID 83709	208-XXXX 658-0097
Employer's Name	Policy Number
Rural Telephone Company	SR83116494, SR-83116551
I hereby authorize my Physician to provide the information below for the purpose of claresponsible for any expenses related to the completion of this form. Signature Date 6	im processing. I understand that I am

PHYSICIAN: PLEASE COMPLETE THE INFORMATION BELOW	AND ATTACH SUPPORTIVE MEDICAL DOCUMENTATION:			
Complete Diagnosis. If surgery performed please describe:				
5/0 +kuni-ted Disc (Immber)				
Now foiled book Syndr	e.w~f			
Diagnostic Code:	Date(3) of Hospitalization; (5)			
Diagnostic Code: 774.7 Has the patient previously had the same or similar condition? Yes	41/1/98 9/12/98,3/3/94			
Has the patient previously had the same or similar condition? Yes Please describe:	No if yes, When? 57 LE 7/24/48			
(is condition due to an Accident? Yes, No If yes, is it work related? Yes No	Date of first treatment for this condition			
Date you advised patient to stop work due to this condition 7/7/				
Date you advised patient to return to work in any capacity				
Name and address of other treating physicians, if known: Nichael	velleted te backe			
Medical Findings (Attach office notes, results of physical examination, radio	Olong, EKG, Jaharatany reports, etc.)			
	oragy, Lica, laboratory raports, etc.)			
+ Screening Spine mass				
,				
Trearmens Coals BENSEYLE FOUR PRIN M	No vo a consular a colo			
	19.1349.6.01.50-2			
6 promit tout it ion 2	Fast Multiple Spins surgeries			
Name of Physician (Print)	Specialty			
R. Tyler Frizzell, M.D., Ph.D.	Vn: State/Zip Code			
Street Address: City/Tov	vn: State/Žip Code			
222 North Second St, Suite 307	Boise ID 83709			
Telephone: Fax 203-344-1000 208-344-	1331 Email			
Signature: JM 7	Duc: 2/7/62			

PLEASE RETURN THIS COMPLETED FORM TO YOUR PATIENT



For All the Commitments You Make'

INSTRUCTIONS: Complete Part I of this form per Short Term Disability guidelines. When forwarding the form to your employee, include a self-addressed envelope. If you have any questions regarding completion of this form, please contact the CNA Claim Processing Center at 1-800-303-9744.

Employer's Name	e Policy Number			e en	
Rural Telephone Cor	vnsqr	SR_831	<u> 16551</u>		
Location Clas		Effective Date of Co		Employer Contribution:	
Glenns Fercy, ID	<u> 07/01/97</u>			100% Pre-tax Post-tax	
Employee's Name		Occupation			
Chris J Dennison		Control1	er		
Employee's Address				Employee's Phone Number	
9975 W Hollandale Dr	, Boise, ID 837	09		<u> 208-658-0097</u>	
Date of Birth Social Security Nur 10/09/50 552-64-784	nber Salary Hourly 9 \$73,542 ann	Wage/Hours Worked U& 1 I v		gularly Worked IM 図T 図 W記 T記 F 🗆 S	
Does job require lifting or carrying?	If yes, indicate maximum am		o be lifted	or carried:	
🔯 Yes 🗀 No	50 pounds				
Briefly describe employee's activities i		ıds:		11 11 11 11 11 11 11 11 11 11 11 11 11	
accounting & billing			noute	t. calculator	
Nature of Disability		12 12 13 14 14 15 15 15 15 15 15 15 15 15 15 15 15 15	Is This	a Work Related Disability?	
Back Pain			1 1	☐ Yes	
Is employee receiving or entitled to receive other benefits? Yes No		urce and amount the em	płuyce is r	eceiving:	
Day Last Worked	Date Employee Expected to R	etura to Work	Sic	k Bank Paid Theough	
•		_	36	5 hours left	
Company Contact Name		Title	•	Work Telephone Number	
James R Martell		<u> President</u>	<u>.</u>	<u> </u>	
Contact's Signature				Date	
	Barrier II. Instructions	to Employee			
Your attending physician should co					
Delay in submitting this form could		ur benefit oavment			
I hereby authorize any physician	•			e nacena haviar any racorde	
dates or information concerning					
representative.	me to idinian additiecol	us as may be reque	sten oy	CHA OF WIELL BUILDINGER	
EMPLOYEE SIGNATURE			Date		
ditt bo t bd difficient					
	I. To Be Completed Sec.	Manualina Dhysisias	Domina'		
·	I. To Be Completed By A		Omy		
Complete Diagnosis with Complication	s (if surgery was performed, pl	ease describe):			
Failded back 5	or hard a convert				
inaultinir Su	ing roles				
Was Patient Hospitalized? Tyes	No Date Admitted		Dare Di:	scharged	
10 07 <u>1000 6-</u>	N. / (
First Date of Treatment for Above Con		Commenced	Last Da	te of Treatment	
2/24/-18	ـ د / 7 / 2	······································	_ G. (
Expected Return to Work Date	Can patient resume texplain:	full duties upon return t	o work? L	Yes <u>□-No</u> If no, please	
nj H					
Is Disability Due to:			Expecte	d Date of Delivery	
☐ Sickness ☐ Injury ☐ Work	Related 🔲 Pregnancy LMP) a		<u> 1 7 7</u>	
Physicians Name and Address B. Tyler Frizzell.	1.D., Ph.D.		; -	o's Telephone Number 344-1000	
Agending Physician's Signature		Later /	Physicia	a's FAX Number	
~ / / /	i	ニムスコールコ		. **** -1/2/ -/ ? ₹ /	
G-132019-2 Online version		ing documentation and/	70°Z		

- 15/00/19/3

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

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CHRIS J. DENNISON,	Case No. CIV02-507-S-LMB
Plaintiff,	NGV 2 0 RECT
CONTINENTAL CASUALTY COMPANY an Illinois corporation; CNA GROUP LIFE ASSURANCE COMPANY, a wholly owned subsidiary of Continental Casualty Company, RURAL TELEPHONE COMPANY, and Idaho corporation,) NOTICE OF SERVICE OF) SUMMONS,) COMPLAINT AND DEMAND) FOR JURY TRIAL))
Defendant.)))

TO: CNA GROUP LIFE ASSURANCE COMPANY
ATTN: JONATHAN D. KANTOR
333 SOUTH WABASH, 43S
CHICAGO, IL 60685

You will please take notice that a due and regular service of a SUMMONS, COMPLAINT AND DEMAND FOR JURY TRIAL in connection with the above-entitled action, was made upon you by HAND DELIVERY on the 12th day of November 2002, by delivering in Boise, Idaho, on the said date to the Director of the Department of Insurance, State of Idaho, who is the duly and regularly appointed Statutory Agent. A copy of each instrument is enclosed herewith to you as provided by law.

at Boise, Idaho, this-14th day of November 2002.

DIRECTOR

Department of Insurance

State of Idaho

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114874 CNA CNA 1012 1010 1010

IN THE UNITED STATES DISTRICT COURT.

FOR THE DISTRICT OF IDAHO

CHRIS J. DENNISON,

Case No. CIV02-507-S-LMB

Plaintiff,

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VŠ.

<u>ΜΟΥ, ΖΌ</u>, Δυνζ

CONTINENTAL CASUALTY COMPANY an Illinois corporation: CNA GROUP LIFE ASSURANCE COMPANY, a wholly owned subsidiary of Continental Casualty Company, RURAL TELEPHONE COMPANY, and Idaho corporation,

Defendant.

NOTICE OF SERVICE OF SUMMONS, COMPLAINT AND DEMAND FOR JURY TRIAL

TO- CONTINENTAL CASUALTY COMPANY

ATTN: JONATHAN D. KANTOR 333 SOUTH WABASH, 43S-CHICAGO, IL 60685

You will please take notice that a due and regular service of a SUMMONS, COMPLAINT AND DEMAND FOR JURY TRIAL in connection with the above-entitled action, was made upon you by HAND DELIVERY on the 12th day of November 2002, by delivering in Boise, Idaho, on the said date to the Director of the Department of Insurance, State of Idaho, who is the duly and regularly appointed Statutory Agent. A copy of each instrument is enclosed herewith to you as provided by law.

IN WITNESS WHEREOF, I have hereunto set my hand and the official seal of this office of the seal of this office of the seal of the seal of this office of the seal of the seal of this office of the seal of the seal of this office of the seal of the seal of this office of the seal of

DIRECTOR

Department of Insurance

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State of Idaho

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COPY

David E. Comstock LAW OFFICES OF COMSTOCK & BUSH 800 West Idaho, Suite 300 P.O. Box 2774 Boise, Idaho 83701-2774 (208)344-7700 ISB No.: 2455

Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

CHRIS J. DENNISON) Case NUV02-507-S-LMB
Plaintiff,)) SUMMONS -) CONTINENTAL CASUALTY COMPAN
CONTINENTAL CASUALTY COMPANY an Illinois corporation; CNA GROUP LIFE ASSURANCE COMPANY, a wholly owned subsidiary of Continental Casualty Company, RURAL TELEPHONE COMPANY, and Idaho corporation	/)))))
Defendants.	,)

TO: CONTINENTAL CASUALTY COMPANY

YOU ARE HEREBY SUMMONED and required to file with the Clerk of this Court and serve upon Plaintiffs' attorney, David E. Comstock, Comstock & Bush, P.O. Box 2774, 800 W. Idaho, Suite 300, Boise, Idaho 83701, an answer to the complaint which is herewith served upon you, within 36 days after service of this summons upon you.

SUMMONS - CONTINENTAL CASUALTY COMPANY - 1

exclusive of the day of service. If you fail to do so, judgment by default may be taken against you for the relief demanded in the complaint.

CAMERON S. BURKE	OCT 3 0 2002
Clerk	Date
JEANIE M. LOERA	
By Deputy Clerk	

SUMMONS - CONTINENTAL CASUALTY COMPANY - 2

NOV. 20. 2902 | 1:43PM | C

CLED OCT 30 *02 PHO4:34 USCT ID

David E. Comstock
LAW OFFICES OF COMSTOCK & BUSH
800 West Idaho, Suite 300
P.O. Box 2774
Boise, Idaho 83701-2774
(208)344-7700
ISB No.: 2455

Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

CHRIS J. DENNISON

Plaintiff,

COMPLAINT AND DEMAND
FOR JURY TRIAL

CONTINENTAL CASUALTY COMPANY)
an Illinois corporation; CNA GROUP
LIFE ASSURANCE COMPANY, a
wholly owned subsidiary of Continental
Casualty Company, RURAL
TELEPHONE COMPANY, and Idaho
corporation

Defendants.

COMES NOW, Plaintiff Chris J. Dennison by and through his attorneys of record, Comstock & Bush, and as and for a cause of action against the Defendants above-named, states and alleges as follows:

COMPLAINT AND DEMAND FOR JURY TRIAL - 1

NO. 237 (. 1)

I. PARTIES AND JURSIDICTION

- 1. At all times relevant hereto, Plaintiff Chris J. Dennison was a resident of the State of Idaho, County of Ada.
- 2. At all times relevant hereto, Defendant Continental Casualty Company, (hereinafter "Continental") was, upon information and belief, an Illinois Corporation, whose principal place of business is Chicago, Illinois.
- 3. At all times relevant hereto, Defendant CNA Group Life Assurance Company, (hereinafter "CNA") was a wholly owned subsidiary of Defendant Continental and was doing business within the State of Idaho.
- 4. At all times relevant herato, Defendant Rural Telephone Company (herinafter "RTC") was an Idaho Corporation, doing business in the State of Idaho, whose principal place of business is Glenns Ferry, Idaho.
 - 5. Jurisdiction in this court is vested pursuant to 29 U.S.C. §1132(e)(1).

GENERAL ALLEGATIONS

- 7. Plaintiff hereby incorporates and realleges each and every preceding paragraph and incorporate the same by reference herein.
- 8. At all times relevant hereto, Plaintiff Chris J. Dennsion was employed as Controller of Rural Telephone Company.
- 9. At all times relevant hereto, Plaintiff Chris J. Dennison, as an employee of Rural Telephone Company, was an eligible participant in his employer's Group Long-Term Disability Insurance Plan, policy no.: SR83116494. Said Group Long-Term Disability Insurance Plan was purchased from and underwritten by Defendant

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COMPLAINT AND DEMAND FOR JURY TRIAL - 2

Continental and serviced by its wholly owned subsidiary, Defendant CNA.

10. At all times relevant hereto Defendant Rural Telephone Company was the "Plan Administrator" of Plaintiff's Group Long-Term Disability Insurance Plan, policy no.: SR83116494

- 11. Due to failed back syndrome and other on-going medical issues, on February 7, 2002, Plaintiff Chris J. Dennison filed a claim for disability benefits with his employers Group Long-Term Disability Insurance Plan surety. As part of the required documents submitted as proof, Mr. Dennison's claim packet contained the attestation of his treating physician, Tyler Frizzel, M.D., that as of February 7, 2002, Mr. Dennison was totally disabled.
- 12. On or about March 8, 2002, Plaintiff was notified that he was terminated from his employment with Rural Telephone Company, effective March 6, 2002.
- 13. On or about March 12, 2002, Defendant CNA contacted Mr. Dennison's employer, Rural Telephone Company, and spoke with General Manager, Michael Richmond. Mr. Richmond failed to inform CNA that Plaintiff had been terminated and wrongfully informed CNA that Rural Telephone Company would make reasonable accommodations to accommodate Mr. Dennison's physical condition and that Mr. Dennison's position as Controller was strictly sedentary.
- 14. On March 15, 2002, Plaintiff Chris J. Dennison was notified by Defendant CNA that his claim for Long-Term Disability Benefits was denied.
- 15. On or about May 2, Mr. Dennison appealed Defendent CNA's initial denial of disability benefits, enclosing additional medical documentation reflecting that he was

COMPLAINT AND DEMAND FOR JURY TRIAL - 3

totally disabled. Mr. Dennison also informed CNA that Mr. Richmond had given incomplete and inaccurate information.

- 16. Between May 2, 2002 and June 10, 2002, Mr. Dennison submitted additional documentation to Defendant CNA, supporting his claim for Long-Term Disability.
- 17. On or about June 24, 2002, CNA's Appeals Committee notified the Plaintiff that despite the opinion of Tyler Frizzel, M.D., Plaintiff's treating physician, that Mr. Dennison was unable to work, Defendant CNA's final determination was a complete denial of Mr. Dennison's claim for Long-Term Disability Benefits

II. BREACH OF CONTRACT - CONTINENTAL & CNA

- 18. Plaintiff hereby incorporates and realleges each and every preceding paragraph and incorporate the same by reference herein.
- 19. By virtue of the contract of insurance existing between Plaintiff Chris J. Dennison and Defendants, said Defendants owed Mr. Dennison a contractual duty to ensure that his claim for Long-Term Disability Benefits was evaluated and considered in a fair and impartial manner. As set forth above, Plaintiff exhaustively complied with all terms and conditions of said contract during his application for benefits and during the appeal process.
- 20. Defendants have breached the contract of insurance existing between Plaintiff and Defendants by arbitrarily and capriciously denying Mr. Dennison Long-Term Disability Benefits.
- 21. As a direct and proximate result of Defendants' conduct complained of COMPLAINT AND DEMAND FOR JURY TRIAL 4

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DECERTION TIME NOW DO DIVING

herein, Plaintiff has suffered and will continue to suffer a loss of enefits and other consequential economic damages in an amount to be more readily ascertained at trial.

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III. BREACH OF FIDUCIARY DUTY - RURAL TELEPHONE COMPANY

- 22. Plaintiff hereby incorporates and realleges each and every preceding paragraph and incorporate the same by reference herein.
- 23. As the named Plan Administrator for Plaintiff's Group Long-Term
 Disability Insurance Plan, policy no.: SR83116494, Defendant RTC owed Plaintiff a
 fiduciary duty to ensure that his claim for Long-Term Disability Benefits was presented
 to Defendant CNA in a fair and impartial manner.
- 24. Defendant RTC breached this duty by wrongfully informing CNA that Mr. Dennison could work at RTC and that RTC would accommodate his medical condition allowing him to perform his job, when it had no intention of doing so.
- 25. As a direct and proximate result of Defendant's conduct complained of herein, Plaintiff has suffered and will continue to suffer loss of benefits and other consequential economic damages in an amount to be more readily ascertained at trial.

IV. BREACH OF FIDUCIARY DUTY - CNA

- 26. Plaintiff hereby incorporates and realleges each and every preceding paragraph and incorporate the same by reference herein.
- 27. As the party whose duty it was to service the Plaintiff's Group Long-Term Disability Insurance Plan, policy no.: SR83116494, Defendant CNA owed Plaintiff a fiduciary duty to ensure that his claim for Long-Term Disability Benefits was evaluated and considered in a fair and impartial manner.

COMPLAINT AND DEMAND FOR JURY TRIAL - S

- Defendant CNA breached this duty by the existence of its inherent conflict of interest, by ignoring the evidence presented by Plaintiff's own physician and by failing to investigate the validity of the information it was provided by Defendant RTC to the effect that Mr. Dennison could work at RTC and that RTC would accommodate his medical condition allowing him to perform his job, when RTC had no intention of doing so.
- 29. As a direct and proximate result of Defendant's conduct complained of herein, Plaintiff has suffered and will continue to suffer a loss of benefits and other consequential economic damages in an amount to be more readily ascertained at trial.

DAMAGES

- 30. As a direct and proximate result of the Defendants' conduct complained of herein, Plaintiff has suffered the following damages:
- (a) Past and future loss of income and/or benefits which Plaintiff Chris J.

 Dennison would have reasonably expected to receive in Long-Term Disability Benefits; and.
- (b) Attorney fees, penalties, interest, and expenses incurred reasonably related hereto.

DEMAND FOR ATTORNEY FEES

As a result of Defendants' conduct complained of herein, Plaintiff has been compelled to retain the law firm of Comstock & Bush, and has incurred and will incur costs and reasonable attorneys fees related thereto, for which Plaintiff is entitled to a separate award of reimbursement pursuant to Idaho Code Sections 12-120, 41-1329

COMPLAINT AND DEMAND FOR JURY TRIAL - 6

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment against Defendant as follows:

- 1. For prospective loss of income and/or benefits in an amount which shall be more readily ascertained at the time and place set for trial;
 - For prejudgment interest as allowed by law;
 - For an award of costs and attorneys fees reasonably incurred in the
 prosecution of this action;
 - For any penalties provided for by force of law; and,
 - For such other and further relief as this court deems just and equitable in these premises.

DATED This 30 day of October, 2002.

/.)

By:

David E. Comstock, Of the Firm

Attorneys for Elejntiff

COMSTOCK & BUSH



Continental Casalty Company



CNA Plaza A Stock Company Chicago, Illinois 60685

Having issued Folicy No. SR-83116494 to

Rural & Pend Oreille Telephone Companies (Herein called the Employer)

CERTIFIES that You are insured provided that You qualify under the ELIGIBILITY provision, become insured and remain insured in accordance with the terms of the policy. Your insurance is subject to all the definitions, limitations and conditions of the policy. It takes effect on the effective date indicated in the EFFECTIVE DATE provision. This certificate, however, is not the policy. It is merely evidence of insurance provided under the policy. The policy can be amended by mutual consent between the Employer and Us.

This certificate replaces and cancels any other certificate previously issued to *You* under the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, We have discretionary authority to determine Your eligibility for benefits and to interpret the terms and provisions of the policy.

Berard L. Hengerbrugh.
Chairman of the Board

Group Long Term Disability Certificate

SBD1-C

Summary Of Benefits	• • • • • • • • • • • • • • • • • • • •
Are You Eligible For This Insurance?	
When Does Your Insurance Become Effective?	
Who Pays For Your Coverage?	
Is Premium Payable While You Receive Benefits?	
How Do We Define Disability?	4
What Is The Elimination Period And How Is It Satisfied?	
Can You Satisfy Your Elimination Period If You Are Working?	!
What Disability Benefit Are You Eligible To Receive?	
What is Your Benefit And How is it Calculated?	
How Do We Define Earnings?	(
What Are The Deductible Sources Of Income?	,, €
What Other Sources Of Income Are Not Deductible?	
Can You Work And Still Receive Benefits?	
What It The Minimum Monthly Receift Payable Hader This Program?	8
What Happens If Your Other Benefits Increase?	8
How Long Will You Receive Benefits Under This Program?	,, 8
What Happens If Your Disability Recurs?	8
What Are The Exclusions And Limitations Under This Program?	9
How Are Substance Abuse Claims Handled?	9
When Wilt Your Insurance Terminate?	10
Will Coverage Be Continued If You Are Eligible For Leave Under FMLA?	10
What Happens If You Die While Receiving Benefits?	10
Are Day Care Expense Benefits Available While You Are Disabled?	10
What Other Services Are Available To You While You Are Disabled?	11
Presumptive Disability	11
What Are The Claim Filing Requirements?	12
Time And Payment Of Claim	13
What Are The Uniform Provisions?	13
Subrogation / Right Of Reimbursement	14
Fraud	14
General Provisions	14
Glossary	15
EDICA .	17

Note: All terms in *italics* are listed and defined in the Glossary or within the certificate itself. CDI-3AA

SUMMARY OF BENEFITS

Effective As Of: August 1, 1999

LONG TERM DISABILITY PLAN

Policy Effective Date:

August 1, 1999

Policy Number:

SR-83116494

Eligibility:

All active full-time employees who are Actively at Work for the

Employer.

Definition of Full-time:

Employées must be working at least 30 hours per week.

Waiting Period:

For employees in an eligible group on or before August 1, 1999: 30 Days of

continuous active, full-time employment.

For employees entering an eligible group after August 1, 1999: 30 Days of continuous

active, full-time employment.

Elimination Period:

90 Days

Monthly Benefit:

67% of Monthly Earnings to a maximum benefit of \$9,000.00 per

month subject to reduction by deductible sources of income or

Disability Earnings.

Social Security Offset Method:

Family Social Security

Employer Contribution:

100% of premium

Maximum Period Payable:

Age at *Disability* 61 or younger

To Retirement Age*

Maximum Period Payable

Age 62

42 months or to Retirement Age*,

3- --

whichever is longer.

Age 63

36 months or to Retirement Age*,

whichever is longer.

Age 64

30 months or to Retirement Age*,

whichever is longer.

Age 65

24 months or to Retirement Age*,

whichever is longer.

Age 66

21 months or to Retirement Age*,

whichever is longer.

Age 67

18 months or to Retirement Age*,

whichever is longer.

Age 68

15 months or to Retirement Age*,

whichever is longer.

Age 69 or over

12 months

*SOCIAL SECURITY NORMAL RETIREMENT AGES

Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 or later	67 years

Other features:

Waiver of Premium
Work Incentive Benefit
Enhanced Work Incentive Benefit
Minimum Benefit
Recurrent Disability
FMLA Coverage Extension
Survivor Benefit
Day Care Benefit
Worksite Modification Benefit
Vocational Rehabilitation Service
Social Security Assistance
Presumptive Disability

This Summary of Benefits cancels and replaces all other Summaries previously issued to You under the policy. It outlines the policy features. The following pages provide a complete description of the provisions of some

ARE YOU ELIGIBLE FOR THIS INSURANCE?

All active full-time employees who are Actively at Work for the Employer and who have completed the waiting period required by the Employer. The waiting period is stated in the Summary of Benefits.

A "full-time" employee is one who regularly works a minimum of 30 hours per week for the Employer. Part-time, cor-4AA

WHEN DOES YOUR INSURANCE BECOME EFFECTIVE?

If You are eligible as of the Policy Effective Date, Your insurance shall take effect on such Date. If You become eligible after the Policy Effective Date, Your insurance shall become effective on the first of the month that falls on or next follows the date You become eligible.

If, because of *Injury* or *Sickness*, *You* are eligible but not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work*.

WHO PAYS FOR YOUR COVERAGE?

Your employer pays the entire cost of Your coverage.

IS PREMIUM PAYABLE WHILE YOU RECEIVE BENEFITS?

We will waive premium for You during the period of Disability for which the Monthly Benefit is payable under the policy. Premium payment is required during Your Elimination Period. During this period. Your insurance will remain in force. This provision is subject to the Termination of Employee's Insurance provision, except for payment of premium.

HOW DO WE DEFINE DISABILITY?

Disability or Disabled means that You satisfy the Occupation Qualifier or the Earnings Qualifier as defined below.

Occupation Qualifier

"Disability" means that during the Elimination Period and the following 24 months, Injury or Sickness causes physical or mental impairment to such a degree of severity that You are:

- 1. continuously unable to perform the Material and Substantial Duties of Your Regular Occupation; and
- not working for wages in any occupation for which You are or become qualified by education, training or experience.

COI-10AA

After the Monthly Benefit has been payable for 24 months, "Disability" means that Injury or Sickness causes physical or mental impairment to such a degree of severity that You are:

- continuously unable to engage in any occupation for which You are or become qualified by education, training or experience; and
- not working for wages in any occupation for which You are or become qualified by education, training or experience.

CDI-11AA

Earnings Qualifier

You may be considered Disabled during and after the Elimination Period in any Month in which You are Gainfully Employed, if an Injury or Sickness is causing physical or mental impairment to such a degree of severity that You are unable to earn more than 80% of Your Monthly Earnings in any occupation for which You are qualified by education, training or experience. On each anniversary of Your Disability, We will increase the Monthly Earnings by the lesser of the current annual percentage increase in CPI-W. or 10%.

You are not considered to be *Disabled* if You earn more than 80% of Your Monthly Earnings. Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income You receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

LOSS OF PROFESSIONAL LICENSE OR CERTIFICATION

If You require a professional license or certification for Your occupation, loss of that professional license or certification does not in and of itself constitute *Disability* under the Occupation Qualifier or the Earnings Qualifier.

CDI-14AA

WHAT IS THE ELIMINATION PERIOD AND HOW IS IT SATISFIED?

The Elimination Period begins on the day You become Disabled. It is a period of continuous Disability which must be satisfied before You are eligible to receive benefits from Us. You must be continuously Disabled through Your Elimination Period.

If You temporarily recover and return to work, We will treat Your Disability as continuous if You return to work for a period of less than one-half the Elimination Period as shown in the Summary of Benefits not to exceed 90 days. The days that You are not Disabled will not count toward Your Elimination Period.

Any increases You receive in Monthly Earnings during Your return to work period will not be taken into consideration when calculating Your Monthly Benefit.

If You return to work for a period greater than one-half the *Elimination Period*, or 90 days, whichever is less, and become *Disabled* again, You will have to begin a new *Elimination Period*.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided You meet the definition of Disability. CDI-15AA

WHAT DISABILITY BENEFIT ARE YOU ELIGIBLE TO RECEIVE?

If You are Disabled, You are eligible to receive one of the following at any given time: a Monthly Benefit, a Work Incentive Benefit or an Enhanced Work Incentive Benefit. While You are Disabled, You might be eligible to receive one or the other of the above, but You cannot receive more than one of these benefits at the same time.

WHAT IS YOUR BENEFIT AND HOW IS IT CALCULATED?

We will calculate Your Monthly Benefit amount as follows:

- Multiply Your Monthly Earnings by 67%.
- The maximum Monthly Benefit is \$9,000.00.
- 3. Compare the answers from Item 1 and Item 2: The lesser of these two amounts is Your gross Monthly Benefit.
- Deduct other sources of income from Your gross Monthly Benefit. The resulting figure is Your net Monthly Benefit.

We will pay the Monthly Benefit for each Month of Disability which continues after the Elimination Period. The Monthly Benefit will not be payable during the Elimination Period nor beyond the Maximum Period Payable.

If a benefit is payable for less than one month, it will be paid on the basis of 1/20th of the Monthly Benefit for each day of Disability.

HOW DO WE DEFINE EARNINGS?

"Monthly Earnings" will equal the Monthly wage or salary that You were receiving from Your employer on the Date of Disability. It includes:

- employee contributions made through a salary reduction agreement with Your employer to an IRC Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee Retirement Plan or deferred compensation arrangement; and
- amounts contributed to Your fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

- commissions;
- bonusest
- overtime pay;
- 4. Your employer's contribution on Your behalf to a Retirement Plan or deferred compensation arrangement; or any other extra compensation.

CDI-19AA

WHAT ARE THE DEDUCTIBLE SOURCES OF INCOME?

The Monthly Benefit under this policy shall be reduced by:

- 1. Disability benefits paid, payable, or for which there is a right under:
 - a) The Social Security Act, including any amounts for which Your dependents may qualify because of Your Disability;
 - b) Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational *Injury* or *Sickness*;
 - o) Occupational accident coverage provided by or through the Employer;
 - d) Any Statutory Disability Benefit Law;
 - e) The Railroad Retirement Act;
 - f) The Canada Pension Plan, Quebec Pension Plan or any other similar provincial disability or pension plan;
 - g) The Canada Old Age Security Act;
 - h) Any Public Employee Retirement System Plan or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans.
- 2. Disability benefits paid under:
 - a) Any group insurance plan provided by or through the Employer, and
 - b) Any sick leave or salary continuance plan provided by or through the Employer.
- 3. Retirement benefits paid under the Social Security Act including any amounts for which Your dependents may qualify because of Your retirement.
- 4 Retirement and disability benefits paid under a Retirement Plan provided by the Employer except for amounts attributable to Your contributions.
- 5. Any No Fault Auto Motor Vehicle coverage.
- Disbursements received as a shareholder in a Subchapter S Corporation attributable to any period following the Date of Disability.

Proration of Lump Sum Awards

If any benefit described above is paid in a single sum through compromise settlement or as an advance on future liability. We will determine the amount of reduction to Your Monthly Benefit as follows:

- We will divide the amount paid by the number of months for which the settlement or advance was provided; or
- If the number of months for which the settlement or advance was made is not known. We will divide the amount of
 the settlement or advance by the expected remaining number of months for which We will provide benefits for Your
 Disability based on the Proof of Disability which We have, subject to a maximum of 80 months.

CDI-30AA

WHAT OTHER SOURCES OF INCOME ARE NOT DEDUCTIBLE?

We will not reduce Your Monthly nefit by any of the following:

- deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- 2. credit disability insurance;
- pension plans for partners;
- 4. military pension and disability income plans;
- franchise disability income plans;
- 6. individual disability income plans;
- a Retirement Plan from another Employer;
- 8. profit sharing plans;
- thrift or savings plans;
- 10. individual retirement account (IRA);
- 11. tax sheltered annuity (TSA);
- 12. stock ownership plan.

ÇDI-21AA

CAN YOU WORK AND STILL RECEIVE BENEFITS?

While Disabled, You may qualify for the Work Incentive Benefit or the Enhanced Work Incentive Benefit, but not both. CDI-22AA

Work Incentive Benefit

A Work Incentive Benefit will be provided if You are Disabled and Gainfully Employed after the end of the Elimination Period, or after a period during which You received Monthly Benefits.

The Work Incentive Benefit will be calculated during the first 24 months of Gainful Employment as follows:

- The Monthly Benefit amount and Disability Earnings amount will be added together and compared to Monthly
 Earnings.
- 2. If the total amount in Item 1 exceeds 100% of *Monthly Earnings*, the Work Incentive Benefit amount will be equal to the *Monthly Benefit* reduced by the amount of the excess.
- If the total amount in Item 1 does not exceed 100% of Monthly Earnings, the Work Incentive Benefit will be equal to the Monthly Benefit amount.

After the first 24 months of Gainful Employment, the Work Incentive Benefit will be equal to the Monthly Benefit amount less 50% of Disability Earnings.

The Work Incentive Benefit will cease on the earliest of the following: (1) the date You are no longer Disabled; or (2) the end of the Maximum Period Payable.

CDI-23AA

Enhanced Work Incentive Benefit

An Enhanced Work Incentive Benefit will be provided after the end of the *Elimination Period*, or after a period during which You received Monthly Benefits. This benefit is payable if You are still Disabled and are Gainfully Employed in an occupation that has been approved as part of a Rehabilitation Plan.

The Enhanced Work Incentive Benefit will be calculated during the first 24 months of Gainful Employment as follows:

- If Disability Earnings exceed 100% of Monthly Earnings, the Enhanced Work Incentive Benefit will be equal to the Monthly Benefit reduced by the amount of the excess.
- If Disability Earnings do not exceed 100% of Monthly Earnings, the Enhanced Work Incentive Benefit will be equal to the Monthly Benefit.

After the first 24 months of Gainful Employment, the Enhanced Work Incentive Benefit will be equal to the Monthly Benefit less 50% of Disability Earnings.

The Enhanced Work Incentive Benefit will cease on the earliest of the following: (1) as stated in the *Rehabilitation Plan*; (2) the date *You* fail to comply with the requirements of the *Rehabilitation Plan*; (3) the date *You* are no longer *Disabled*; or (4) at the end of the *Maximum Period Payable*.

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WHAT IS THE MINIMUM MONTHLY BENEFIT PAYABLE UNDER THIS PROCRAM?

In no event will the Monthly Barrel payable for Disability be reduced to learn \$100.00 or 10% of Your Monthly Benefit prior to the reductions stated above, whichever is greater. The Minimum Monthly Benefit does not apply if You are Gainfully Employed.

CDI-25AA

WHAT HAPPENS IF YOUR OTHER BENEFITS INCREASE?

The Monthly Benefit, after the reductions stated above, if any, will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which there is a right under any Deductible Source of Income shown above. CDI-26AA

HOW LONG WILL YOU RECEIVE BENEFITS UNDER THIS PROGRAM?

We send You a payment each month up to the maximum duration of benefit based on Your age at Disability so long as You continue to be Disabled according to the terms of the policy:

Age at <i>Disability</i> 61 or younger	Maximum Period Payable To Retirement Age*
Age 62	42 months or to Retirement Age* whichever is longer.
Age 63	36 months or to Retirement Age* whichever is longer.
Age 64	30 months or to Retirement Age" whichever is longer
Age 65	24 months or to Retirement Age* whichever is longer.
Age 66	21 months or to Retirement Age" whichever is longer.
Age 67	18 months or to Retirement Age* whichever is longer.
Age 68	15 months or to Retirement Age* whichever is longer.
Age 69 or over	12 months

***SOCIAL SECURITY NORMAL RETIREMENT AGES**

Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 or later	67 years
ÇDI-27AA	- -

WHAT HAPPENS IF YOUR DISABILITY RECURS?

If Disability for which benefits were payable ends but recurs due to the same or related causes tess than 6 months after the end of a prior Disability, it will be considered a resumption of the prior Disability. Such recurrent Disability shall be subject to the provisions of the policy that were in effect at the time the prior Disability began.

Disability which recurs more than 6 months after the end of a prior Disability are subject to:

- a new. Elimination Period;
- 2) a new Maximum Period Payable; and
- 3) the other provisions of the policy that are in effect on the date the Disability recurs.

Disability must recur while Your coverage is in force under the policy.

WHAT ARE THE EXCLUSIONS AND LIMITATIONS UNDER THIS PROGRAM?

The policy does not cover any loss caused by, contributed to, or resulting from: CDIX-1AA

 declared or undeclared war or an act of either; CDIX-2AA

Disability beyond 24 months after the Elimination Period if it is due to a Mental Disorder of any type. Confinement
in a Hospital or institution licensed to provide care and treatment for mental illness will not be counted as part of
the 24-month limit;

CDIX-3AA

- a Pre-existing Condition; CDIX-4AA
- attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness; CDIX-5AA
- commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
 CDIX-6AA
- Disability beyond 24 months after the Elimination Period if it is due to a diagnosed condition which manifests itself
 primarily with Self-Reported Symptom(s).

 CDIX-7AA

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

CDIX-12AA

Benefits will not be payable if it is determined that *You* are eligible to participate in vocational rehabilitation services designed to assist in returning *You* to employment and *You* refuse to participate.

CDIX-13AA

HOW ARE SUBSTANCE ABUSE CLAIMS HANDLED?

The policy does not cover any loss caused by or resulting from any substance abuse (drug or alcohol) related *Disability* beyond 24 months after the *Elimination Period*.

You must be participating in an appropriate treatment program. A treatment program is any substance abuse treatment program approved by the State.

The cost of the treatment program will be borne by You, or another group plan of Your Employer (such as a group health plan or Employee Assistance Program) if one is available and covers this type of treatment.

In no event will Monthly Benefit payments be made beyond the earlier of the date:

- 1. 24 Monthly Benefit payments have been made; or
- You refuse to participate in an appropriate, available treatment program, or You leave the treatment program prior to completion; or
- You are no longer following the requirements of Your treatment plan under the program; or
- You complete the initial treatment plan, exclusive of any aftercare or follow-up services.

In no event will *Monthly Benefits* be payable beyond the *Maximum Pariod Payable*. CDI-29AA

WHEN WILL YOUR INSURANCE TERMINATE?
Your coverage will terminate on earliest of the earliest of the following dates:

- 1. the date the policy is terminated; or
- the premium due date if the Employer fails to pay the required premium for You, except for an inadvertent error; or
- the date You:
 - (a) are no longer a member of a class eligible for this insurance, or
 - (b) withdraw from the program, or
 - (c) are retired or pensioned, or
 - (d) cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless We and the Employer have agreed in writing in advance of the leave to continue insurance during such period.

Termination will not affect a covered loss which began before the date of termination. CDI-30AA

WILL COVERAGE BE CONTINUED IF YOU ARE ELIGIBLE FOR LEAVE UNDER FMLA?

In the event You are eligible for and Your Employer approves a leave under the Family and Medical Leave Act of 1993 (FMLA), insurance will continue for a period of up to 12 weeks following the date the leave begins, provided the Employer continues paying the required premium.

You are eligible for leave under this Act in order to provide care:

- After the birth of a child; or
- 2. After the legal adoption of a child; or
- 3. After the placement of a foster child in Your home; or
- To a Spouse, child or parent due to their serious illness; or
- 5. For Your own serious health condition.

White granted a Family and Medical Leave Absence:

- The Employer will pay the required premium according to the terms of the policy;
- 2. You will be considered Actively at Work while on an approved Family and Medical Leave Absence; and
- 3. Coverage will terminate if You do not return to work as scheduled according to the terms of Your agreement with the Employer.

CDI-31AA

WHAT HAPPENS IF YOU DIE WHILE RECEIVING BENEFITS?

If You die after having received the benefit provided by the policy for at least 12 successive months and during a period for which benefits are payable. We will pay a Survivor Income Benefit. This benefit is equal to the amount. You were last entitled to receive for the month preceding death.

The Survivor Income Benefit shall be payable on a monthly basis immediately after We receive written proof of Your death. It is payable for 6 months. The benefit shall accrue from Your date of death.

This benefit is payable to the beneficiary, if any, named by You under the policy. If no such beneficiary exists, the benefit will be payable in accordance with the TIME AND PAYMENT OF CLAIM provision. CDI-33AA

ARE DAY CARE EXPENSE BENEFITS AVAILABLE WHILE YOU ARE DISABLED?

While Disabled and receiving the Enhanced Work Incentive Benefit, You will be reimbursed for Day Care Expenses for each Eligible Child.

"Day Care Expenses" mean monthly expenses, up to \$350,00 per child per month, charged by a licensed Day Care Provider who is not a member of Your immediate family or living in Your residence.

"Eligible Child" is Your degendent child under age 13 who lives with You and is:

- Your child or Your Spouse's child;
- 2. Your legally adopted child; or
- A child for whom You are legal guardian.

You must supply satisfactory proof to Us that You incurred such charges. CDI-34AA

WHAT OTHER SERVICES ARE AVAILABLE TO YOU WHILE YOU ARE DISABLED?
If You are Disabled and eligible receive Disability benefits under the policy We will We will evaluate You for eligibility to receive any of the following. We will make the final determination for any of the following benefits or services.

Worksite Modification Benefit

We will assist You and Your employer in identifying modifications. We agree are likely to help. You remain at work or return to work. This agreement will be in writing and must be signed by You, Your employer and Us.

When this occurs, We will reimburse Your employer for the cost of the modification, up to the greater of: 1) \$1,500.00 or 2) 2 months of Your net Monthly Benefit.

Vocational Rehabilitation Service

Rehabilitation services are available when We determine that these services are reasonably assumed to assist in returning You to Gainful Employment. Vocational Rehabilitation services might include one or more of the following:

- job modification;
- ioo retraining;
- job placement;
- 4. other activities.

Eligibility for Vocational Rehabilitation Services is based upon. Your education, training, work experience and physical and/or mental capacity. To be considered for rehabilitation services:

- Your Disability must prevent You from performing Your Regular Occupation;
- You must have the physical and/or mental capacities necessary for successful completion of a rehabilitation. program, and
- There must be a reasonable expectation that rehabilitation services will help You return to Gainful Employment.

Social Security Assistance

When necessary. We will provide an advocate for You, in applying for and securing Social Security Disability awards. When We determine that Social Security Assistance is appropriate for You, it is provided at no additional cost to You. ÇDI-35AA

WHAT OTHER BENEFITS ARE AVAILABLE?

CDIO-1AA

PRESUMPTIVE DISABILITY

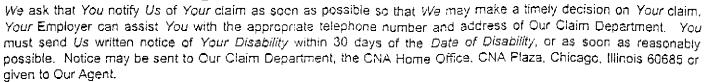
When Injury results in any of the Specific Losses listed below within 365 days after the date of the Injury, We will consider You to be Disabled. You shall be entitled to payment of the Monthly Benefit after the Elimination Period. This benefit is payable for the length of time stated below. Payment of the Presumptive Disability Benefit will caase on Your date of death.

Specific Loss	Months Payable
Loss of both hands	46 months
Loss of both feet	46 months
Loss of the entire sight of both eyes	46 months
Loss of one hand and one foot	46 months
Loss of one hand and the entire sight of one eye	46 months
Loss of one foot and the entire sight of one eye	48 months
Loss of one hand	23 months
Loss of one foot	23 months
Loss of the entire sight of one eye	15 months
Loss of the thumb and index finger of either hand	12 months

After payment of this Minimum Benefit, benefits may continue subject to the other provisions of the policy. If more than one loss results from any one Injury, We will pay only for that loss with the greatest number of Months Payable.

"Specific Loss" means, with respect to hand or foot, the actual, complete and permanent severance through or above the wrist or ankle joint; with respect to eye, the irrecoverable loss of the entire sight thereof; and with respect to thumb and index finger, the actual, complete and permanent severance through or above the metacarpophalanceal joints. CDIO-10AA

WHAT ARE THE CLAIM FILING EQUIREMENTS? Initial Notice of Claim



Written Proof of Loss

Within 15 days of our being notified in writing of Your claim, We will supply You with the necessary claim forms. The claim form is to be completed and signed by You, Your Employer and Your Doctor. If You do not receive the appropriate claim forms within 15 days, then You will be considered to have met the requirements for written proof of loss if We receive written proof which describes the occurrence, extent and nature of loss.

Time Limit for Filing Your Claim

The time limit for filing Your claim is that You must furnish Us with written proof of loss within 90 days after the end of Your Elimination Period. The length of the Elimination Period is stated in the Summary of Benefits section of the policy. If it is not possible to give Us written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless You are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, You can request that benefits be paid for late claims if You can show that:

- 1. It was not reasonably possible to give written proof during the 1 year period, and
- 2. Proof of loss satisfactory to Us was given as soon as was reasonably possible.

Proof of Disability

The following items, supplied at Your expense, must be a part of Your proof of ioss. Failure to do so may delay, suspend or terminate Your benefits:

- The date Your Disability began;
- 2. The cause of Your Disability:
- 3. The prognosis of Your Disability;
- 4. Proof that You are receiving Appropriate and Regular Care for Your condition from a Doctor, who is someone other than You or a member of Your immediate family, whose specialty or expertise is the most appropriate for Your disabling condition(s) according to Generally Accepted Medical Practice.
- Objective medical findings which support Your Disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for Your disabling condition(s).
- The extent of Your Disability, including restrictions and limitations which are preventing. You from performing. Your Regular Occupation.
- Appropriate documentation of Your Monthly Earnings. If applicable, appropriate, regular monthly documentation
 of Your Disability Earnings.
- If You were contributing to the premium cost, Your employer must supply proof of Your appropriate payroll
 deductions.
- 9. The name and address of any Hospital or Health Care Facility where You have been treated for Your Disability.
- If applicable, proof of incurred costs covered under other benefits included in the policy.

Continuing Proof of Disability

You may be asked to submit proof that You continue to be *Disabled* and are continuing to receive *Appropriate* and *Regular Care* of a *Doctor*. Requests of this nature will only be as often as *We* feel reasonably necessary. If so, this will be at Your expense and must be received within 30 days of *Our* request.

Physical Examination

At Our expense, We have the right to have a Doctor examine You as often as reasonably necessary while the claim continues. Failure to comply with this examination will suspend or terminate benefits, unless. We agree You have a valid and ecceptable reason for not complying

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- Authorization and Documentation You Will Be Asked to Supply 1. You will be required to providing and authorization for Us to obse all reasonably necessary medical. igned authorization for Us to obtain and re financial or other non-medical information which support Your Disability claim. Failure to submit this information will deny, suspend or terminate Your benefits.
- 2. You will be required to supply proof that You have applied for other Deductible Income Benefits such as Workers' Compensation or Social Security Disability benefits, when applicable.
- 3. You will be required to notify Us when You receive or are awarded other Deductible Income Benefits. You must tell Us the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

TIME AND PAYMENT OF CLAIM

CDI-36AA

As soon as We have all necessary substantiating documentation for Your Disability claim. Your benefit will be paid on a Monthly basis, so long as You continue to qualify for it.

We will pay benefits to You unless otherwise indicated. If You die while Your claim is open, any due and unpaid Disability benefit will be paid to Your named beneficiary, if any.

If there is no surviving beneficiary, payment may be made, at Our option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: Your: (1) Spouse; (2) children including legally adopted children; (3) parents; or (4) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release. We may pay up to \$1,000 to any relative or beneficiary of Yours whom We deem to be entitled to this amount. We will be discharged to the extent of such payment made by Us in good faith. CDI-37AA

CAN YOU ASSIGN YOUR BENEFITS?

Your benefits are not assignable, which means that You may not transfer Your benefits to anyone else. CDI-38AA

WHAT WILL HAPPEN IF A CLAIM IS OVERPAID?

A claim overpayment can occur when You receive a retroactive payment from a Deductible Source of Income; when We inadvertently make an error in the calculation of Your claim; or if fraud occurs.

In an overpayment situation, We will determine the method by which the repayment is made. You will be required to sign an agreement with Us which details the source of the overpayment, the total amount We will recover and the method of recovery. If Monthly Benefits are suspended while recovery of the overpayment is being made, suspension will also apply to the Minimum Monthly Benefit payable under the policy.

The overpayment amount equals the amount We paid in excess of the amount We should have paid under the policy. CDI-39AA

WHAT ARE THE UNIFORM PROVISIONS?

Entire Contract: Changes

The policy, the Employer's application, Your certificate of coverage, and Your application, if any, and any other attached papers, form the entire contract between the parties. No change in the policy is valid enless approved in writing by one of Our officers. No agent has the right to change the policy or to waive any of its provisions.

Statements on the Application

Any statement made by the Employer or You, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Employer or You, whoever made the statement. No statement of the Employer will be used to void the policy after it has been in force for 2 years. No statement of Yours will be used in defense of a claim after You have been insured for 2 years, except for fraudulent misstatements.

Legal Actions

No legal action of any kind may be filed against Us:

- within the 60 days after proof of Disability has been given; or
- more than 3 years after proof of Disability must be filed, unless the law in the state where. You live allows a longer 000081 period of time.

Conformity with State Statutes,

If any provision of the policy counts with the statutes of the state in which the policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

SUBROGATION / RIGHT OF REIMBURSEMENT

When any claim payment is made, We reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with Us.

We will bear any expenses associated with Our pursuit of subrogation or recovery. CDI-41AA

FRAUD

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.

GENERAL PROVISIONS

We have the right to inspect all of the Employer's records on the policy at any reasonable time. This right will extend until: (1) 2 years after termination of the policy; or (2) all claims under the policy have been settled, whichever is later.

The policy is in the Employer's possession and may be inspected by *You* at any time during normal business hours at the Employer's office.

The policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance. CDI-43AA

GLOSSARY

"Actively at Work" or "Active Work" means the employee must be:

- working at the Employer's usual place of business, or on assignment for the purpose of furthering the Employer's business; and
- 2. performing the Material and Substantial Duties of the Insured Employee's Regular Occupation on a full-time basis.
- "Appropriate and Regular Care" means that You are regularly visiting a Doctor as frequently as medically required to meet Your basic health needs. The effect of the care should be of demonstrable medical value for Your disabling condition(s) to effectively attain and/or maintain Maximum Medical Improvement.

 CDID-4AA
- "Date of Disability" is the date We determine Your Injury or Sickness impairs Your ability to perform Your Regular Occupation.

 CDID-5AA
- "Disability" or "Disabled" means that You satisfy either the Occupation Qualifier or the Earnings Qualifier.
 CDID-6AA
- "Disability Earnings" is the wage or salary You earn from Gainful Employment after a Disability begins. It does not include Social Security or any other Disability payment You receive as a result of Your Disability.

 CDID-7AA
- "Doctor" means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither You nor a member of Your immediate family. A licensed medical practitioner is a Doctor if applicable state law requires that such practitioners be recognized for purposes of certification of Disability, and the treatment provided by the practitioner is within the scope of his or her license.

 CDID-8AA
- "Elimination Period" means the number of calendar days at the beginning of a continuous period of Disability for which no benefits are payable. The Elimination Period is shown in the Summary of Benefits.
 CDID-9AA
- "Gainful Employment" or "Gainfully Employed" means the performance of any occupation for wages, remuneration or profit, for which You are qualified by education, training or experience on a full-time or part-time basis, for the Employer or another employer, and which We approve and for which We reserve the right to modify approval in the future.

 CDID-10AA
- "Generally Accepted Medical Practice" or "Generally Accepted in the Practice of Medicine" means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.

 CDID-11AA
- "Hospital or Health Care Facility" is a legally operated, accredited facility licensed to provide full-time care and treatment for condition causing Your Disability. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.

 CDID-12AA
- "Injury" means bodily injury caused by an accident which results, directly and independently of all other causes, in Disability which begins while Your coverage is in force.
 CDID-13AA.
- "Insured Employee" means an employee whose insurance is in force under the terms of the policy.

 GDID-14AA
- "Male pronoun" whenever used includes the female. 0010-1644
- "Material and Substantial Duties" means the necessary functions of Your Regular Occupation which cannot be reasonably omitted or altered. 000

"Maximum Medical Improvement is that level at which, based on reason medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.

CDID-18AA

"Mental Disorder" means a disorder found in the current diagnostic standards in the American Psychiatric Association.

CDID-19AA

"Monthly Benefit" and "Maximum Period Payable" mean that benefit and those periods shown in the Summary of Benefits which apply to You.
CDID-20AA

"Pre-existing Condition" means a condition for which medical treatment or advice was rendered, prescribed or recommended within 3 months prior to Your effective date of insurance. A condition shall no longer be considered pre-existing if it causes Disability which begins after You have been insured under the policy for a period of 12 months.

"Regular Occupation" means the occupation that You are performing for income or wages on Your Date of Disability. It is not limited to the specific position You held with Your employer.

CDID-22BA

"Rehabilitation Plan" means a written agreement between You and Us. Its purpose is to assist You in returning to Gainful Employment. The Rehabilitation Plan will outline the time and dates of the vocational rehabilitation services, Our responsibilities, Your responsibilities and the responsibilities of any third party which might be involved. The Rehabilitation Plan will be at Our expense, at the expense of the third party, or a shared expense of Ours and a third party. At Our discretion, the Rehabilitation Plan will include the Day Care Expense Benefit.

"Retirement Plan" means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.
CDID-24AA

"Self-Reported Symptoms" means the symptoms of which You tell Your Doctor, and are not verifiable or quantifiable using tests, procedures, or clinical examinations Generally Accepted in the Practice of Medicine. Examples of these manifestations include the following, but are not limited to: fatigue, pain, headaches, stiffness, soreness, tinnitus (ringing in the ears), dizziness, numbness, or loss of energy.

CDID-25AA

"Sickness" means sickness or disease causing Disability which begins while Your coverage is in force.
CDID-25AA

"Summary of Benefits" means the summary which is a part of this certificate. CDID-28AA

"We", "Our" and "Us" mean the Continental Casualty Company, Chicago, Illinois, CDID-29AA

"You", "Your" and "Yours" means the employee to whom this certificate is issued and whose insurance is in force under the terms of the policy.
CDID-30AA

ERISA YOUR RIGHTS UNDER ERISA



The following section contains information provided to You by the Plan Administrator of Your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974. It does not constitute a part of the Plan or of any insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to Your Plan Administrator.

SUMMARY PLAN DESCRIPTION

Name of Plan

The Plan for which this Summary Plan Description is provided is known as the:

Rural & Pend Oreille Telephone Companies Group Disability Plan

Maintenance of Plan

The Plan is maintained by:

Rural & Pend Oreille Telephone Companies 104 West Madison Ave. Glenns Ferry, ID 83623

Employer Identification Number and Plan Number

The employer identification number (EIN) assigned by the Internal Revenue Service to the Plan sponsor is: 93-0739703

The Plan Number assigned by the Plan sponsor is:

Type of Welfare Plan

The Plan is a group disability plan.

Administration of Plan

The Plan is administered by the Plan Administrator through an insurance contract purchased from Continental Casualty Company.

Plan Administrator

Rural & Pend Oreille Telephone Companies 104 West Madison Ave. Glenns Ferry, ID 83623

Hereinafter referred to as the Administrator. The Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the Plan.

Agent for Service of Legal Process

The person designated as agent for service of legal process upon the Plan is:

Rural & Pend Oreille Telephone Companies 104 West Madison Ave. Glenns Ferry, ID 83623

In addition, service of process may be made upon the Administrator.

<u>union85</u>

Eligibility and Benefits

The Plan's requirements respect eligibility for participation, the conditions paraining to eligibility to receive benefits and description or summary of the benefits are listed in the certificate portion of this booklet.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are listed in the certificate portion of this booklet.

Sources of Plan Contributions

Contributions to the Plan are made by the employer.

Medium for Providing Benefits

Benefits under the Plan are provided in accordance with the provisions of Group Insurance Policy Number SR-83116494 issued by Continental Casualty Company, CNA Plaza, Chicago, Illinois, 60685.

Date of End of Plan's Fiscal Year

The date of the end of each year for purposes of maintaining the Plan's fiscal records is December 31.

Claim Procedures

Presenting Claims for Benefits

Claim forms may be obtained from: the Employer.

Please see Your insurance certificate or booklet for the requirements of the Group Insurance Policy as to notice of claims.

Claims Denial Procedure

Any denial of a claim for benefits will be provided by the insurance company and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information. You might be required to provide and an explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure. You, Your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 60 days after receipt of the request for the review.

If there are special circumstances, the decision will be made as soon as possible, but not later than 120 days after receipt of the request for the review. If such an extension of time is needed, You will be notified in writing prior to the beginning of the time extension period. The decision after Your review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

Statement of ERISA Rights

The statement of ERISA Rights is required by federal law and regulation.

As a participant in this Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Ptan's annual financial report. The Administrator is required by law to furnish each
 participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate *Your* Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of *You* and other Plan participants and beneficiaries.

No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from printing a welfare benefit or exercising Your attended ERISA.

If Your claim for a welfare benefit is denied in whole or in part. You must receive a written explanation of the reason for the denial. You have the right to have the insurance company review and reconsider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials for the Plan and do not receive them within 30 days. You may file suit in federal court. In such a case, the court may require the Administrator to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay the cost and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about Your Plan, You should contact the Administrator. If You have any questions about this statement or about Your rights under ERISA. You should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. ERISA

Continental Case Ity Company



CNA Plaza A Stock Company Chicago, Illinois 60685 Rural & Pend Oreille Telephone Companies EMPLOYER: 104 West Madison Ave. P.O. Box 969 Glenns Ferry, ID 83623 POLICY NUMBER: SR-83116494 EFFECTIVE DATE: August 1, 1999 ANNIVERSARY DATE: August 1 We agree with the Employer to insure certain eligible employees of the Employer. We promise to pay benefits for loss covered by the policy in accordance with its provisions. The policy is issued in consideration of the payment of premium and the statements made in the Application. The policy takes effect on the Effective Date stated. All insurance periods will be computed from that date. The policy remains in force for the period for which premium has been paid. It may be renewed for further successive periods by payment of premium as stated in the policy. All periods of insurance begin and end at 12:01 A.M., Standard Time, at the Employer's address as stated in this contract, and on the application. DI-1AA SIGNED FOR THE CONTINENTAL CASUALTY COMPANY Bernard L. Hengelmuch.
Chairman of the Board Countersigned by _____ Licensed Resident Agent

Group Long Term Disability Policy

SBOI-P

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Note: All terms in *italics* are listed and defined in the Glossary or within the policy itself. DI-2AA

SUMMARY OF BENEFITS

Effective As Of: August 1, 1999

gust 1, 1999

LONG TERM DISABILITY PLAN

Policy Effective Date:

August 1, 1999

Policy Number:

SR-83116494

Eligibility:

All active full-time employees who are Actively at Work for the

Employer.

Definition of Full-time:

Employees must be working at least 30 hours per week.

Waiting Period:

For employees in an eligible group on or before August 1, 1999: 30 Days of

continuous active, full-time employment.

For employees entering an eligible group after August 1, 1999: 30 Days of continuous

active, full-time employment.

Elimination Period:

90 Days

Monthly Benefit:

67% of Monthly Earnings to a maximum benefit of \$9,000.00 per

month subject to reduction by deductible sources of income or

Disability Earnings.

Social Security Offset Method:

Family Social Security

Employer Contribution:

100% of premium

Maximum Period Payable:

Age at Disability Maximum Period Payable 61 or younger To Retirement Age*

Age 62 42 months or to Retirement Age*,

whichever is longer.

Age 63 36 months or to Retirement Age*,

whichever is longer.

Age 64 30 months or to Retirement Age*,

whichever is longer.

Age 65 24 months or to Retirement Age*,

whichever is longer.

Age 66 21 months or to Retirement Age",

whichever is longer.

Age 67 18 months or to Retirement Age*,

whichever is longer.

Age 68 15 months or to Retirement Age*,

whichever is longer.

12 months

Age 69 or over

*SOCIAL SECURITY NORMAL RETIREMENT AGES

Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months

Other features:

Waiver of Premium

Work Incentive Benefit

Enhanced Work Incentive Benefit

Minimum Benefit Recurrent Disability

FMLA Coverage Extension

Survivor Benefit Day Care Benefit

Worksite Modification Benefit Vocational Rehabilitation Service

Social Security Assistance Presumptive Disability

This Summary of Benefits cancels and replaces all other Summaries previously issued under the policy. It outlines the policy features. The following pages provide a complete description of the provisions of the policy.

HOW IS PREMIUM CALCULATED?

Premium is calculated by multiplying the total insured *Monthly Earnings* by .0083. Do not include *Monthly Earnings* for any individual in excess of \$13,432.84 per Month in the premium calculation.

WHEN IS PREMIUM PAID?

The policy is issued in consideration of the payment in advance of the monthly premium. The monthly premium is calculated at the premium rate stated above. Such payment must be made by the beginning of each monthly premium accounting period and must be accompanied by a premium adjustment report.

If an addition, termination or change in insurance takes place other than on a regular due date, any premium adjustment will take effect on the next due date.

If notice of termination or change is received more than six months after the termination or change became effective, We are not required to give a refund or credit for the period in excess of six months.

DI-3AA

IS PREMIUM PAYABLE WHILE AN EMPLOYEE RECEIVES BENEFITS?

We will waive premium for an *Insured Employee* during the period of *Disability* for which the *Monthly Benefit* is payable under the policy. Premium payment is required during the *Insured Employee's Elimination Period*. During this period, the *Insured Employee's* insurance will remain in force. This provision is subject to the Termination of Employee's Insurance provision, except for payment of premium.

DI-4AA

IS THERE A GRACE PERIOD FOR PREMIUM PAYMENT?

Yes. A grace period of 31 days from the date premium is due is allowed for the payment of premium. The policy will remain in force during the grace period. The Employer is liable for all premiums due for the period the policy remains in force including the grace period, if it applies.

DI-5AA

WHAT IS THE POLICY TERM AND PREMIUM RATE GUARANTEE?

We agree to renew the policy and not to change the premium rate. Such agreement shall be valid until August 1, 2001 if:

- 1. There are no changes made to the program:
- There is a minimum of 10 Insured Employees and there is less than a 25% change to the number of Insured
 Employees since the effective date of the policy; and
- There are no new classes of employees, subsidiaries, affiliated companies or new acquisitions of the Employer added after the effective date of the policy.

DI-6AA

WHO MAY CANCEL THE POLICY OR A PLAN UNDER THE POLICY?

The policy or a plan under the policy on be canceled by the Employer. We may only cancel or offer to modify the policy if:



1. there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or

there is less than 100% participation of those eligible employees for an Employer paid plan;

3. the Employer does not promptly provide Us with information that is reasonably required;

the Employer fails to perform any of its obligations that relate to the policy;

fewer than 10 employees are insured under the policy;

6. the Employer fails to pay any premium within the 31 day Grace Period.

If We cancel the policy, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date. DI-7AA

WHAT HAPPENS IF AN INADVERTENT ERROR OCCURS?

Clerical error or omissions will not: (1) deprive an employee of insurance which would otherwise have been granted; or (2) effect or continue insurance which otherwise would not be in force. An adjustment of premium will be made. AA8-IO

WILL CERTIFICATES BE ISSUED?

We will deliver certificates of insurance to the Employer for issuance to each Insured Employee. The certificates will describe the benefits, to whom they are payable, the policy limitations and where the policy may be inspected. DI-9AA

Continental Casualty Company



CNA Plaza A Stock Company Chicago, Illinois 60685

Having issued Policy No. SR-83116494 to

Rural & Pend Creille Telephone Companies (Herein called the Employer)

CERTIFIES that You are insured provided that You qualify under the ELIGIBILITY provision, become insured and remain insured in accordance with the terms of the policy. Your insurance is subject to all the definitions, limitations and conditions of the policy. It takes effect on the effective date indicated in the EFFECTIVE DATE provision. This certificate, however, is not the policy. It is merely evidence of insurance provided under the policy. The policy can be amended by mutual consent between the Employer and Us.

This certificate replaces and cancels any other certificate previously issued to *You* under the policy. CDI-1AA

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, We have discretionary authority to determine Your eligibility for benefits and to interpret the terms and provisions of the policy.

Bernsel L. Hengelinesh Chairman of the Board

Group Long Term Disability Certificate

\$801-C

ARE YOU ELIGIBLE FOR THIS INSURANCE?

All active full-time employees who have completed the waiting period required by the Employer. The waiting period is stated in the Summary of Benefits.

A "full-time" employee is one who regularly works a minimum of 30 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible.

WHEN DOES YOUR INSURANCE BECOME EFFECTIVE?

If You are eligible as of the Policy Effective Date, Your insurance shall take effect on such Date. If You become eligible after the Policy Effective Date, Your insurance shall become effective on the first of the month that falls on or next follows the date You become eligible.

If, because of *Injury* or *Sickness*, You are eligible but not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work*.
COI-5AA

WHO PAYS FOR YOUR COVERAGE?

Your employer pays the entire cost of Your coverage. CDI-6AA

IS PREMIUM PAYABLE WHILE YOU RECEIVE BENEFITS?

We will waive premium for You during the period of Disability for which the Monthly Benefit is payable under the policy. Premium payment is required during Your Elimination Period. During this period, Your insurance will remain in force. This provision is subject to the Termination of Employee's Insurance provision, except for payment of premium.

HOW DO WE DEFINE DISABILITY?

Disability or Disabled means that You satisfy the Occupation Qualifier or the Earnings Qualifier as defined below.

Occupation Qualifier

"Disability" means that during the Elimination Period and the following 24 months, Injury or Sickness causes physical or mental impairment to such a degree of severity that You are:

- 1. continuously unable to perform the Material and Substantial Duties of Your Regular Occupation; and
- not working for wages in any occupation for which You are or become qualified by education, training or experience.

CDI-10AA

After the *Monthly Benefit* has been payable for 24 months, "*Disability*" means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that You are:

- continuously unable to engage in any occupation for which You are or become qualified by education, training or experience; and
- 2. not working for wages in any occupation for which You are or become qualified by education, training or experience.

CDI-11AA

Earnings Qualifier

You may be considered Disabled during and after the Elimination Period in any Month in which You are Gainfully Employed, if an Injury or Sickness is causing physical or mental impairment to such a degree of severity that You are unable to earn more than 80% of Your Monthly Earnings in any occupation for which You are qualified by education, training or experience. On each anniversary of Your Disability, We will increase the Monthly Earnings by the lesser of the current annual percentage increase in CPI-W, or 10%.

You are not considered to be *Disabled* if You earn more than 80% of Your Monthly Earnings. Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income You receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

LOSS OF PROFESSIONAL LICENSE OR CERTIFICATION

If You require a professional license or certification for Your occupation, loss of the professional license or certification does not in and of itself constitute *Description* bility under the Occupation Qualifier or the Parnings Qualifier.

WHAT IS THE ELIMINATION PERIOD AND HOW IS IT SATISFIED?

The Elimination Period begins on the day You become Disabled. It is a period of continuous Disability which must be satisfied before You are eligible to receive benefits from Us. You must be continuously Disabled through Your Elimination Period.

If You temporarily recover and return to work, We will treat Your Disability as continuous if You return to work for a period of less than one-half the Elimination Period as shown in the Summary of Benefits not to exceed 90 days. The days that You are not Disabled will not count toward Your Elimination Period.

Any increases You receive in Monthly Earnings during Your return to work period will not be taken into consideration when calculating Your Monthly Benefit.

If You return to work for a period greater than one-half the Eilmination Period, or 90 days, whichever is less, and become Disabled again, You will have to begin a new Elimination Period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided You meet the definition of Disability.

WHAT DISABILITY BENEFIT ARE YOU ELIGIBLE TO RECEIVE?

If You are Disabled, You are eligible to receive one of the following at any given time: a Monthly Benefit, a Work Incentive Benefit or an Enhanced Work Incentive Benefit. While You are Disabled, You might be eligible to receive one or the other of the above, but You cannot receive more than one of these benefits at the same time.

WHAT IS YOUR BENEFIT AND HOW IS IT CALCULATED?

We will calculate Your Monthly Benefit amount as follows:

- Multiply Your Monthly Earnings by 67%.
- 2. The maximum Monthly Benefit is \$9,000.00.
- 3. Compare the answers from Item 1 and Item 2: The lesser of these two amounts is Your gross Monthly Benefit.
- 4. Deduct other sources of income from Your gross Monthly Benefit. The resulting figure is Your net Monthly Benefit.

We will pay the Monthly Benefit for each Month of Disability which continues after the Elimination Period. The Monthly Benefit will not be payable during the Elimination Period nor beyond the Maximum Period Payable.

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the *Monthly Benefit* for each day of *Disability*.

CDI-17AA

HOW DO WE DEFINE EARNINGS?

"Monthly Earnings" will equal the Monthly wage or salary that You were receiving from Your employer on the Date of Disability. It includes:

- employee contributions made through a salary reduction agreement with Your employer to an IRC Section 401(k).
 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee Retirement
 Plan or deferred compensation arrangement; and
- 2 amounts contributed to Your fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

- 1. commissions;
- bonuses;
- overtime pay;
- Your employer's contribution on Your behalf to a Retirement Plan or deferred compensation a other extra compensation.

CDI-19AA

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WHAT ARE THE DEDUCTIBLE SOURCES OF INCOME?

- The Monthly Benefit under this political shall be reduced by:

 1. Disability benefits paid, payable or for which there is a right under:
 - a) The Social Security Act, including any amounts for which Your dependents may qualify because of Your
 - b) Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational Injury or Sickness;
 - Occupational accident coverage provided by or through the Employer;
 - d) Any Statutory Disability Benefit Law;
 - e) The Railroad Retirement Act:
 - f) The Canada Pension Plan, Quebec Pension Plan or any other similar provincial disability or pension plan:
 - g) The Canada Old Age Security Act;
 - h) Any Public Employee Retirement System Plan or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans.
- 2. Disability benefits paid under:
 - a) Any group insurance plan provided by or through the Employer, and
 - b) Any sick leave or salary continuance plan provided by or through the Employer.
- 3. Retirement benefits paid under the Social Security Act including any amounts for which Your dependents may gualify because of Your retirement.
- 4. Retirement and disability benefits paid under a Retirement Plan provided by the Employer except for amounts attributable to Your contributions.
- Any No Fault Auto Motor Vehicle coverage.
- 6. Disbursements received as a shareholder in a Subchapter S Corporation attributable to any period following the Date of Disability.

Proration of Lump Sum Awards

If any benefit described above is paid in a single sum through compromise settlement or as an advance on future liability, We will determine the amount of reduction to Your Monthly Benefit as follows:

- 1. We will divide the amount paid by the number of months for which the settlement or advance was provided; or
- 2. If the number of months for which the settlement or advance was made is not known, We will divide the amount of the settlement or advance by the expected remaining number of months for which We will provide benefits for Your Disability based on the Proof of Disability which We have, subject to a maximum of 60 months. CDI-20AA

WHAT OTHER SOURCES OF INCOME ARE NOT DEDUCTIBLE?

We will not reduce Your Monthly Benefit by any of the following:

- 1. deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- credit disability insurance;
- pension plans for partners;
- military pension and disability income plans;
- 5. franchise disability income plans;
- 6. individual disability income plans;
- a Retirement Plan from another Employer;
- 8. profit sharing plans;
- 9. thrift or savings plans;
- 10. individual retirement account (IRA);
- 11, tax sheltered annuity (TSA);
- 12. stock ownership plan.

COI-21AA

CAN YOU WORK AND STILL RECEIVE BENEFITS?

While Disabled, You may qualify for the Work Incentive Benefit or the Enhanced Work Incentive Benefit, but not both. CDI-22AA

Work Incentive Benefit

A Work Incentive Benefit will be provided if You are Disabled and Gainfully Employed after the end of the Elimination Period, or after a period during which You received Monthly Benefits.

The Work Incentive Benefit will be calculated during the first 24 months of Gainful Employment as follows:

- 1. The Monthly Senefit amount and Disability Earnings amount will be added together and compared to Monthly Earnings.
- 2. If the total amount in Item 1 exceeds 100% of Monthly Earnings, the Work Incentive Benefit amount will be equal to the Monthly Senefit reduced by the amount of the excess. 220000

3. If the total amount in Item 1 does not exceed 100% of Monthly Earnings, the Work Incentive Benefit will be equal to the Monthly Benefit amount.

After the first 24 months of Gainful Employment, the Work Incentive Benefit will be equal to the Monthly Benefit amount less 50% of Disability Earnings.

The Work Incentive Benefit will cease on the earliest of the following: (1) the date You are no longer Disabled; or (2) the end of the Maximum Period Payable.

CDI-23AA

Enhanced Work Incentive Benefit

An Enhanced Work Incentive Benefit will be provided after the end of the *Elimination Period*, or after a period during which You received *Monthly Benefits*. This benefit is payable if You are still *Disabled* and are *Gainfully Employed* in an occupation that has been approved as part of a *Rehabilitation Plan*.

The Enhanced Work Incentive Benefit will be calculated during the first 24 months of Gainful Employment as follows:

- 1. If Disability Earnings exceed 100% of Monthly Earnings, the Enhanced Work Incentive Benefit will be equal to the Monthly Benefit reduced by the amount of the excess.
- 2. If Disability Earnings do not exceed 100% of Monthly Earnings, the Enhanced Work Incentive Benefit will be equal to the Monthly Benefit.

After the first 24 months of Gainful Employment, the Enhanced Work Incentive Benefit will be equal to the Monthly Benefit less 50% of Disability Earnings.

The Enhanced Work Incentive Benefit will cease on the earliest of the following: (1) as stated in the *Rehabilitation Plan*; (2) the date *You* fail to comply with the requirements of the *Rehabilitation Plan*; (3) the date *You* are no longer *Disabled*; or (4) at the end of the *Maximum Period Payable*.

CDI-24AA

WHAT IS THE MINIMUM MONTHLY BENEFIT PAYABLE UNDER THIS PROGRAM?

In no event will the *Monthly Benefit* payable for *Disability* be reduced to less than \$100.00 or 10% of *Your Monthly Benefit* prior to the reductions stated above, whichever is greater. The Minimum *Monthly Benefit* does not apply if *You* are *Gainfully Employed*.

CDI-25AA

WHAT HAPPENS IF YOUR OTHER BENEFITS INCREASE?

The Monthly Benefit, after the reductions stated above, if any, will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which there is a right under any Deductible Source of Income shown above. CDI-26AA

HOW LONG WILL YOU RECEIVE BENEFITS UNDER THIS PROGRAM?

We send You a payment each month up to the maximum duration of benefit based on Your age at Disability so long as You continue to be Disabled according to the terms of the policy:

Age at <i>Disability</i>	Maximum Period Payable
61 or younger	To Retirement Age*
Age 62	42 months or to Retirement Age*,
	whichever is longer.
Age 63	36 months or to Retirement Age*,
	whichever is longer.
Age 64	30 months or to Retirement Age*.
	whichever is longer,
Age 65	24 months or to Retirement Age*,
	whichever is longer.
Age 66	21 months or to Retirement Age*,
	whichever is longer.
Age 67	13 months or to Retirement Age*,
	whichever is longer.
Age 68	15 months or to Retirement Age*,
	whichever is longer.
Age 69 or over	12 months
	10

*SOCIAL SECURITY NORMAL REMEMENT AGES

Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 or later	67 years
CDI-27AA	•

WHAT HAPPENS IF YOUR DISABILITY RECURS?

If Disability for which benefits were payable ends but recurs due to the same or related causes less than 6 months after the end of a prior Disability, it will be considered a resumption of the prior Disability. Such recurrent Disability shall be subject to the provisions of the policy that were in effect at the time the prior Disability began.

Disability which recurs more than 6 months after the end of a prior Disability are subject to:

- a new Elimination Period;
- a new Maximum Period Payable; and
- 3) the other provisions of the policy that are in effect on the date the Disability recurs.

Disability must recur while Your coverage is in force under the policy. CDI-28AA

WHAT ARE THE EXCLUSIONS AND LIMITATIONS UNDER THIS PROGRAM?

The policy does not cover any loss caused by, contributed to, or resulting from: CDIX-1AA

- declared or undeclared war or an act of either; CDIX-2AA
- Disability beyond 24 months after the Elimination Period if it is due to a Mental Disorder of any type. Confinement
 in a Hospital or institution licensed to provide care and treatment for mental illness will not be counted as part of
 the 24-month limit;

CDIX-3AA

- a Pre-existing Condition;
 CDIX-4AA
- attempted suicide, while sane or insane, or intentional self-inflicted injury or sickness;
 CDIX-5AA
- commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred.
 CDIX-6AA
- Disability beyond 24 months after the Elimination Period if it is due to a diagnosed condition which manifests itself
 primarily with Self-Reported Symptom(s).

Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

CDIX-12AA

Benefits will not be payable if it is determined that You are eligible to participate in vocational rehabilitation services designed to assist in returning You employment and You refuse to participate CDIX-13AA

HOW ARE SUBSTANCE ABUSE CLAIMS HANDLED?

The policy does not cover any loss caused by or resulting from any substance abuse (drug or alcohol) related *Disability* beyond 24 months after the *Elimination Period*.

You must be participating in an appropriate treatment program. A treatment program is any substance abuse treatment program approved by the State.

The cost of the treatment program will be borne by You, or another group plan of Your Employer (such as a group health plan or Employee Assistance Program) if one is available and covers this type of treatment.

In no event will Monthly Benefit payments be made beyond the earlier of the date:

- 1. 24 Monthly Benefit payments have been made; or
- 2. You refuse to participate in an appropriate, available treatment program, or You leave the treatment program prior to completion; or
- 3. You are no longer following the requirements of Your treatment plan under the program; or
- 4. You complete the initial treatment plan, exclusive of any aftercare or follow-up services.

In no event will Monthly Senefits be payable beyond the Maximum Period Payable. CDI-29AA

WHEN WILL YOUR INSURANCE TERMINATE?

Your coverage will terminate on the earliest of the following dates:

- 1. the date the policy is terminated; or
- 2. the premium due date if the Employer fails to pay the required premium for You, except for an inadvertent error; or
- 3. the date You:
 - (a) are no longer a member of a class eligible for this insurance, or
 - (b) withdraw from the program, or
 - (c) are retired or pensioned, or
 - (d) cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless We and the Employer have agreed in writing in advance of the leave to continue insurance during such period.

Termination will not affect a covered loss which began before the date of termination. CDI-30AA

WILL COVERAGE BE CONTINUED IF YOU ARE ELIGIBLE FOR LEAVE UNDER FMLA?

In the event You are eligible for and Your Employer approves a leave under the Family and Medical Leave Act of 1993 (FMLA), insurance will continue for a period of up to 12 weeks following the date the leave begins, provided the Employer continues paying the required premium.

You are eligible for leave under this Act in order to provide care:

- 1. After the birth of a child; or
- 2. After the legal adoption of a child; or
- 3. After the placement of a foster child in Your home; or
- 4. To a Spouse, child or parent due to their serious illness; or
- 5. For Your own serious health condition.

While granted a Family and Medical Leave Absence:

- 1. The Employer will pay the required premium according to the terms of the policy;
- 2. You will be considered Actively at Work while on an approved Family and Medical Leave Absence; and
- 3. Coverage will terminate if You do not return to work as scheduled according to the terms of Your agreement with the Employer.

CDI-31AA

WHAT HAPPENS IF YOU DIE WHILE RECEIVING BENEFITS?

If You die after having received the benefit provided by the policy for at least 12 successive months and during a period for which benefits are payable. We will pay a Survivor Income Benefit. This benefit is equal to the amount. You were last entitled to receive for the month preceding death.

The Survivor Income Benefit shall payable on a monthly basis immediately ter We receive written proof of Your death. It is payable for 6 months, the benefit shall accrue from Your date of death.

This benefit is payable to the beneficiary, if any, named by *You* under the policy. If no such beneficiary exists, the benefit will be payable in accordance with the TIME AND PAYMENT OF CLAIM provision. cDI-33AA.

ARE DAY CARE EXPENSE BENEFITS AVAILABLE WHILE YOU ARE DISABLED?

While Disabled and receiving the Enhanced Work Incentive Benefit, You will be reimbursed for Day Care Expenses for each Eligible Child.

"Day Care Expenses" mean monthly expenses, up to \$350.00 per child per month, charged by a licensed Day Care Provider who is not a member of Your immediate family or living in Your residence.

"Eligible Child" is Your dependent child under age 13 who lives with You and is:

- 1. Your child or Your Spouse's child;
- 2. Your legally adopted child; or
- 3. A child for whom You are legal guardian.

You must supply satisfactory proof to Us that You incurred such charges. CDI-34AA

WHAT OTHER SERVICES ARE AVAILABLE TO YOU WHILE YOU ARE DISABLED?

If You are Disabled and eligible to receive Disability benefits under the policy, We will evaluate You for eligibility to receive any of the following. We will make the final determination for any of the following benefits or services.

Worksite Modification Benefit

We will assist You and Your employer in identifying modifications. We agree are likely to help. You remain at work or return to work. This agreement will be in writing and must be signed by You, Your employer and Us.

When this occurs, We will reimburse Your employer for the cost of the modification, up to the greater of: 1) \$1,500.00 or 2) 2 months of Your net Monthly Benefit.

Vocational Rehabilitation Service

Rehabilitation services are available when We determine that these services are reasonably assumed to assist in returning You to Gainful Employment. Vocational Rehabilitation services might include one or more of the following:

- 1. job modification;
- job retraining;
- job placement;
- 4. other activities.

Eligibility for Vocational Rehabilitation Services is based upon. Your education, training, work experience and physical and/or mental capacity. To be considered for rehabilitation services:

- 1. Your Disability must prevent You from performing Your Regular Occupation;
- You must have the physical and/or mental capacities necessary for successful completion of a rehabilitation program, and
- 3. There must be a reasonable expectation that rehabilitation services will help. You return to Gainful Employment.

Social Security Assistance

When necessary, We will provide an advocate for You, in applying for and securing Social Security Disability awards. When We determine that Social Security Assistance is appropriate for You, it is provided at no additional cost to You. CDI-35AA

WHAT OTHER BENEFITS ARE AVAILABLE?

CDIO-1AA

PRESUMPTIVE DISABILITY

When Injury results in any of the cific Losses listed below within 365 day after the date of the Injury, We will consider You to be Disabled. You shall be entitled to payment of the Monthly Benefit after the Elimination Period. This benefit is payable for the length of time stated below. Payment of the Presumptive Disability Benefit will cease on Your date of death.

Specific Loss	Months Payable
Loss of both hands	46 months
Loss of both feet	46 months
Loss of the entire sight of both eyes	46 months
Loss of one hand and one foot	46 months
Loss of one hand and the entire sight of one eye	46 months
Loss of one foot and the entire sight of one eye	46 months
Loss of one hand	
Loss of one foct.	23 months
Loss of the entire sight of one eye	15 months
Loss of the thumb and index finger of either hand	12 months

After payment of this Minimum Benefit, benefits may continue subject to the other provisions of the policy. If more than one loss results from any one *Injury*, We will pay only for that loss with the greatest number of Months Payable.

"Specific Loss" means, with respect to hand or foot, the actual, complete and permanent severance through or above the wrist or ankle joint; with respect to eye, the irrecoverable loss of the entire sight thereof, and with respect to thumb and index finger, the actual, complete and permanent severance through or above the metacarpophalangeal joints.

WHAT ARE THE CLAIM FILING REQUIREMENTS?

Initial Notice of Claim

We ask that You notify Us of Your claim as soon as possible so that We may make a timely decision on Your claim. Your Employer can assist You with the appropriate telephone number and address of Our Claim Department. You must send Us written notice of Your Disability within 30 days of the Date of Disability, or as soon as reasonably possible. Notice may be sent to Our Claim Department, the CNA Home Office, CNA Plaza, Chicago, Illinois 60685 or given to Our Agent.

Written Proof of Loss

Within 15 days of our being notified in writing of Your claim, We will supply You with the necessary claim forms. The claim form is to be completed and signed by You, Your Employer and Your Doctor. If You do not receive the appropriate claim forms within 15 days, then You will be considered to have met the requirements for written proof of loss if We receive written proof which describes the occurrence, extent and nature of loss.

Time Limit for Filing Your Claim

The time limit for filing Your claim is that You must furnish Us with written proof of loss within 90 days after the end of Your Elimination Period. The length of the Elimination Period is stated in the Summary of Benefits section of the policy. If it is not possible to give Us written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless You are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, You can request that benefits be paid for late claims if You can show that:

- 1. It was not reasonably possible to give written proof during the 1 year period, and
- Proof of loss satisfactory to Us was given as soon as was reasonably possible.

Proof of Disability

The following items, supplied at Your expense, must be a part of Your proof of loss. Failure to do so may delay, suspend or terminate Your benefits;

- The date Your Disability began;
- The bause of Your Disability;
- 3. The prognosis of Your Disability;

- 4. Proof that You are receiving Appropriate and Regular Care for Your condition from a Doctor, who is someone other than You or a member of Your mediate family, whose specialty or expense is the most appropriate for Your disabling condition(s) according to Generally Accepted Medical Practice.
- Objective medical findings which support Your Disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for Your disabiling condition(s).
- The extent of Your Disability, including restrictions and limitations which are preventing You from performing Your Regular Occupation.
- 7. Appropriate documentation of Your Monthly Earnings. If applicable, appropriate, regular monthly documentation of Your Disability Earnings.
- 8. If You were contributing to the premium cost, Your employer must supply proof of Your appropriate payroll deductions.
- 9. The name and address of any Hospital or Health Care Facility where You have been treated for Your Disability.
- If applicable, proof of incurred costs covered under other benefits included in the policy.

Continuing Proof of Disability

You may be asked to submit proof that You continue to be *Disabled* and are continuing to receive *Appropriate* and *Regular Care* of a *Doctor*. Requests of this nature will only be as often as *We* feel reasonably necessary. If so, this will be at *Your* expense and must be received within 30 days of *Our* request.

Physical Examination

At Our expense. We have the right to have a Doctor examine You as often as reasonably necessary while the claim continues. Failure to comply with this examination will suspend or terminate benefits, unless. We agree You have a valid and acceptable reason for not complying.

Authorization and Documentation You Will Be Asked to Supply

- You will be required to provide signed authorization for Us to obtain and release all reasonably necessary medical, financial or other non-medical information which support Your Disability claim. Failure to submit this information will deny, suspend or terminate Your benefits.
- You will be required to supply proof that You have applied for other Deductible Income Benefits such as Workers'
 Compensation or Social Security Disability benefits, when applicable.
- You will be required to notify Us when You receive or are awarded other Deductible Income Benefits. You must tell Us the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

 CDI-36AA

TIME AND PAYMENT OF CLAIM

As soon as We have all necessary substantiating documentation for Your Disability claim, Your benefit will be paid on a Monthly basis, so long as You continue to qualify for it.

We will pay benefits to You unless otherwise indicated. If You die while Your claim is open, any due and unpaid Disability benefit will be paid to Your named beneficiary, if any.

If there is no surviving beneficiary, payment may be made, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your:* (1) *Spouse*; (2) children including legally adopted children; (3) parents; or (4) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release. We may pay up to \$1,000 to any relative or beneficiary of Yours whom We deem to be entitled to this amount. We will be discharged to the extent of such payment made by Us in good faith.

CAN YOU ASSIGN YOUR BENEFITS?

Your benefits are not assignable, which means that You may not transfer Your benefits to anyone else. CDI-38AA

WHAT WILL HAPPEN IF A CLAIM IS OVERPAID?

A districtiverpayment can occur when You receive a retroactive payment from a Deductible Source of Income; when We inadvertently make an error in the calculation of Your claim; or if fraud occurs.

In an overpayment situation, We will determine the method by which the repayment is made. You will be required to sign an agreement with Us which tails the source of the overpayment, the all amount We will recover and the method of recovery. If Monthly Benefits are suspended while recovery of the overpayment is being made, suspension will also apply to the Minimum Monthly Benefit payable under the policy.

The overpayment amount equals the amount We paid in excess of the amount We should have paid under the policy.

WHAT ARE THE UNIFORM PROVISIONS?

Entire Contract; Changes

The policy, the Employer's application, Your certificate of coverage, and Your application, if any, and any other attached papers, form the entire contract between the parties. No change in the policy is valid unless approved in writing by one of Our officers. No agent has the right to change the policy or to waive any of its provisions.

Statements on the Application

Any statement made by the Employer or You, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Employer or You, whoever made the statement. No statement of the Employer will be used to void the policy after it has been in force for 2 years. No statement of Yours will be used in defense of a claim after You have been insured for 2 years, except for fraudulent misstatements.

Legal Actions

No legal action of any kind may be filed against Us:

- 1. within the 60 days after proof of Disability has been given; or
- 2. more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Conformity with State Statutes

If any provision of the policy conflicts with the statutes of the state in which the policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

CDI-40AA

SUBROGATION / RIGHT OF REIMBURSEMENT

When any claim payment is made, We reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with Us.

We will bear any expenses associated with *Our* pursuit of subrogation or recovery.

FRAUD

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.

CDI-42AA

GENERAL PROVISIONS

We have the right to inspect all of the Employer's records on the policy at any reasonable time. This right will extend until: (1) 2 years after termination of the policy; or (2) all claims under the policy have been settled, whichever is later.

The policy is in the Employer's possession and may be inspected by You at any time during normal business hours at the Employer's office.

The policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

GLOSSARY

"Actively at Work" or "Active Work" means the employee must be:

- 1. working at the Employer's usual place of business, or on assignment for the purpose of furthering the Employer's business; and
- 2. performing the Material and Substantial Duties of the Insured Employee's Regular Occupation on a full-time basis, CDID-1AA
- "Appropriate and Regular Care" means that You are regularly visiting a Doctor as frequently as medically required to meet Your basic health needs. The effect of the care should be of demonstrable medical value for Your disabling condition(s) to effectively attain and/or maintain Maximum Medical Improvement.
- "Date of Disability" is the date We determine Your Injury or Sickness impairs Your ability to perform Your Regular Occupation.
 CDID-5AA
- "Disability" or "Disabled" means that You satisfy either the Occupation Qualifier or the Earnings Qualifier.
- "Disability Earnings" is the wage or salary You earn from Gainful Employment after a Disability begins. It does not include Social Security or any other Disability payment You receive as a result of Your Disability.

 CDID-7AA
- "Doctor" means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither You nor a member of Your immediate family. A licensed medical practitioner is a Doctor if applicable state law requires that such practitioners be recognized for purposes of certification of Disability, and the treatment provided by the practitioner is within the scope of his or her license.
- "Elimination Period" means the number of calendar days at the beginning of a continuous period of Disability for which no benefits are payable. The Elimination Period is shown in the Summary of Benefits.
 CDID-9AA
- "Gainful Employment" or "Gainfully Employed" means the performance of any occupation for wages, remuneration or profit, for which You are qualified by education, training or experience on a full-time or part-time basis, for the Employer or another employer, and which We approve and for which We reserve the right to modify approval in the future.

 CDID-10AA
- "Generally Accepted Medical Practice" or "Generally Accepted in the Practice of Medicine" means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.

 CDID-11AA
- "Hospital or Health Care Facility" is a legally operated, accredited facility licensed to provide full-time care and treatment for condition causing Your Disability. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.

 CDID-12AA
- "Injury" means bodily injury caused by an accident which results, directly and independently of all other causes, in Disability which begins while Your coverage is in force. COID-13AA
- "Insured Employee" means an employee whose insurance is in force under the terms of the policy. COID-14AA
- "Male pronoun" whenever used includes the female. CDID-16AA
- "Material and Substantial Duties" means the necessary functions of Your Regular Occupation which cannot be reasonably omitted or altered.

 CDID-17AA

"Maximum Medical Improvements is that level at which, based on reasonal medical probability, further material recovery from, or lasting improvement to, an Injury or Sickness can no longer be reasonably anticipated.

CDID-18AA

"Mental Disorder" means a disorder found in the current diagnostic standards in the American Psychiatric Association.

CDID-19AA

"Monthly Benefit" and "Maximum Period Payable" mean that benefit and those periods shown in the Summary of Benefits which apply to You.

CDID-20AA

"Pre-existing Condition" means a condition for which medical treatment or advice was rendered, prescribed or recommended within 3 months prior to Your effective date of insurance. A condition shall no longer be considered pre-existing if it causes Disability which begins after You have been insured under the policy for a period of 12 months. CDID-218A

"Regular Occupation" means the occupation that You are performing for income or wages on Your Date of Disability. It is not limited to the specific position You held with Your employer, CDID-22BA

"Rehabilitation Plan" means a written agreement between You and Us. Its purpose is to assist You in returning to Gainful Employment. The Rehabilitation Plan will outline the time and dates of the vocational rehabilitation services. Our responsibilities, Your responsibilities and the responsibilities of any third party which might be involved. The Rehabilitation Plan will be at Our expense, at the expense of the third party, or a shared expense of Ours and a third party. At Our discretion, the Rehabilitation Plan will include the Day Care Expense Benefit.

"Retirement Plan" means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.

CDID-24AA

"Self-Reported Symptoms" means the symptoms of which You tell Your Doctor, and are not verifiable or quantifiable using tests, procedures, or clinical examinations Generally Accepted in the Practice of Medicine. Examples of these manifestations include the following, but are not limited to: fatigue, pain, headaches, stiffness, soreness, tinnitus (ringing in the ears), dizziness, numbness, or loss of energy.

CDID-25AA

"Sickness" means sickness or disease causing Disability which begins while Your coverage is in force. CDID-26AA

"Summary of Benefits" means the summary which is a part of this certificate, CDID-28AA

"We", "Our" and "Us" mean the Continental Casualty Company, Chicago, Illinois, CDID-29AA

"You", "Your" and "Yours" means the employee to whom this certificate is issued and whose insurance is in force under the terms of the policy.
CDID-30AA

ERISA YOUR RIGHTS UNDER ERISA



The following section contains information provided to You by the Plan Administrator of Your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974. It does not constitute a part of the Plan or of any insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to Your Plan Administrator.

SUMMARY PLAN DESCRIPTION

Name of Plan

The Plan for which this Summary Plan Description is provided is known as the:

Rural & Pend Oreille Telephone Companies Group Disability Plan

Maintenance of Plan

The Plan is maintained by:

Rural & Pend Oreille Telephone Companies 104 West Madison Ave. Glenns Ferry, ID 83623

Employer Identification Number and Plan Number

The employer identification number (EIN) assigned by the Internal Revenue Service to the Plan sponsor is: 93-0739703

The Plan Number assigned by the Plan sponsor is:

Type of Welfare Plan

The Plan is a group disability plan,

Administration of Plan

The Plan is administered by the Plan Administrator through an insurance contract purchased from Continental Casualty Company.

Plan Administrator

Rural & Pend Oreille Telephone Companies 104 West Madison Ave. Glenns Ferry, ID 83623

Hereinafter referred to as the Administrator. The Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the Plan.

Agent for Service of Legal Process

The person designated as agent for service of legal process upon the Plan is:

Rural & Pend Oreille Telephone Companies 104 West Madison Ave. Glenns Ferry, ID 83623

In addition, service of process may be made upon the Administrator.

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Eligibility and Benefits

The Plan's requirements respecting abbility for participation, the conditions per using to eligibility to receive benefits and description or summary of the benefits are listed in the certificate portion of this booklet.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are listed in the certificate portion of this booklet.

Sources of Plan Contributions

Contributions to the Plan are made by the employer.

Medium for Providing Benefits

Benefits under the Plan are provided in accordance with the provisions of Group Insurance Policy Number SR-83116494 issued by Continental Casualty Company, CNA Plaza, Chicago, Illinois, 60685.

Date of End of Plan's Fiscal Year

The date of the end of each year for purposes of maintaining the Plan's fiscal records is December 31.

Claim Procedures

Presenting Claims for Benefits
 Claim forms may be obtained from: the Employer.

Please see Your insurance certificate or booklet for the requirements of the Group Insurance Policy as to notice of claims.

Claims Denial Procedure

Any denial of a claim for benefits will be provided by the insurance company and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information. You might be required to provide and an explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure. You, Your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 60 days after receipt of the request for the review.

If there are special circumstances, the decision will be made as soon as possible, but not later than 120 days after receipt of the request for the review. If such an extension of time is needed. You will be notified in writing prior to the beginning of the time extension period. The decision after Your review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

Statement of ERISA Rights

The statement of ERISA Rights is required by federal law and regulation.

As a participant in this Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- 1. Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halfs, all Plan documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- 2. Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
- 3. Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries.

No one, including Your employer, Your union, or any other person, may fire You ptherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

If Your claim for a welfare benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the insurance company review and reconsider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials for the Plan and do not receive them within 30 days, You may file suit in federal court. In such a case, the court may require the Administrator to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay the cost and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about Your Plan, You should contact the Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, fisted in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Continental Casualty Company



CNA Plaza A Stock Company		
Chicago, Illinois 60685		

APPLICATION

is hereby made to the Continental Casualty Company for Group Disability Income Insurance by

	is nereby made to the	Continental Casdarty Comp	my for Group Disability income insurance by
1.	Employer:	Rural & Pend Oreille Teleph	one Companies
2.	Address:	104 West Madison Ave. P.O. Box 969 Glenns Ferry, ID 83623	
3.	To be effective in the State	of IDAHO	and governed by the laws thereof.
4.	Coverage applied for :	Policy #: SR-83116494	
		Short Term Disability	
		X Long Term Disability	
5.	Eligibility: The classes of individuals e	igible for coverage are identifie	d in the policy.
6.	August 1, 1999 provided the Office, CNA Plaza, Chicago, premium has been paid and the Individuals eligible have	e Application is accepted in wr Illinois, 60685. It is agreed the Las to benefits requiring contr	1 A.M. Standard Time at the Applicant's address on ting by the Continental Casualty Company at its Home at the policy(ies) cannot become effective until a deposit butions by the individuals insured, until at least 75% of applicant further agrees that, as to benefits not requiring its will be insured.
	By:		WITNESS:
	Applica	nt .	WITNESS: Licensed Resident Agent
	Title	<u> </u>	
ear	Date	, <u>.</u> ,	

Continental Casualty Company

Long Term Disability Insurance Program Administration Manual

designed for

Rural & Pend Oreille Telephone Companies



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GROUP LONG TERM DISABILITY INSURANCE ADMINISTRATION MANUAL

This manual is supplied to assist you with administration of your Group Long Term Disability policy. It contains information on all aspects of the program. It does not replace the policy. Please read your policy before attempting to administer the program. If you have any questions about the content or procedures described within, please contact us.

Policy Information:

Your Group Long Term Disability policy is effective August 1, 1999.

Your Group Long Term Disability policy number is SR-83116494.

Be sure to include this policy number on all correspondence relating to this coverage.

Important Addresses and Phone/Fax Numbers:

Account Service or Underwriting Questions

CNA Special Benefits SBU P.O. Box 25942 Overland Park, KS 66225-5942

Fax #: (913) 661-5777 Toll-free #: (800) 255-7214

Premium Payment Only

CNA Group Benefits 75 Remittance Dr - Suite 1641 Chicago, IL 60675-1641

Claim Filing or Claim Questions

Disability Commercial Accounts P.O. Box 946730 Maitland, FL 32794-6730

Fax #: (407) 919-6402 Toll-free #: (800) 262-6279

Who is Eligible For This Insurance? Employee Eligibility:

All active full-time employees who are "Actively at Work" for the Employer.

Employer full-time service period for employees in an eligible class on or before the policy effective date: 30 Days. Employer full-time service period for employees in an eligible class after the policy effective date: 30 Days.

A "full-time" employee is one who regularly works a minimum of 30 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible.

"Actively at Work" means an employee is at your usual place of business or on assignment, and performing their regular job on a full-time basis.

When Does Insurance Become Effective For Individual Employees?

Employees who fulfill the eligibility requirements (shown above) on or before the policy effective date, will have their insurance take effect on the policy effective date.

Employees who fulfill the eligibility requirements (shown above) after the policy effective date, will have their insurance take effect on the first day of the month that falls on or next follows the date the employee becomes eligible for this coverage.

What If The Employee Is Not "Actively At Work" On Their Effective Date?

<u>Injury and Sickness</u> - If the employee is not "Actively At Work" because of *Injury or Sickness* on the date the insurance coverage would have otherwise taken effect, the employee's insurance will become effective on the day the employee returns to "Active Work".

<u>Holidays</u>, Saturday, Sunday - If the day the employee would otherwise be insured occurs on a Saturday, Sunday or holiday, the employee's insurance will become effective on that day if the employee is able to perform their regular schedule on that day and was "Actively at Work" on the last regularly scheduled work day.

<u>Vacation</u> - Normal vacation is considered active employment. If the day the employee would otherwise be insured occurs white the employee is on a bona fide vacation from work, the employee's insurance will become effective on that day.

What Are the Enrollment Procedures?

Enrollment forms are not needed for your plan because you are paying all of the premium for your eligible employees. All employees who qualify based on the eligibility requirements stated in the previous section are automatically insured as of the date shown above.

Beneficiary Designation and Changes

The Preferential Beneficiary clause of the Payment of Claims provision of the policy determines the beneficiary if there are any accrued benefits payable after the claimant's death. However, some employees may wish to designate a different beneficiary. Therefore, we are enclosing a supply of Beneficiary Designation cards (Form 8G-61470). Keep a completed card with your employee records. A new card must be completed to make a change.

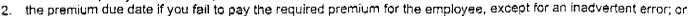
Certificates

A supply of insurance certificates will be sent to you. You should give one to each insured employee. When you have only a 30-day supply, please contact us at the Account Service address shown in the "Important Addresses" page of this manual so that we can send another supply to you.

When Does An Employee's Coverage End?
An employee's insurance will termin on the

on the earliest of the following dates:

the date the policy is terminated; or



3. the date the employee:

a) is no longer a member of a class eligible for this insurance, or

b) withdraws from the program, or

c) is retired or pensioned, or

d) ceases work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless we and you have agreed in writing to continue insurance during such period.

Termination will not affect a covered loss which began before the date of termination. Mark all of your records immediately when an employee's insurance terminates.

Who Pays the Premium?

You are paying all premium cost for your Long Term Disability insurance program.

What Is The Cost Of This Insurance?

The cost for Long Term Disability insurance coverage is a rate of .0083 multiplied times the total insured payroll for the month. This rate should not be applied to an employee's monthly salary in excess of \$13,432.84.

is Premium Payable For Disabled Employees?

While the employee is satisfying the Long Term Disability elimination period, premium should continue to be paid for their coverage. Once an employee begins to receive Long Term Disability benefits, further Long Term Disability premium payment is waived. Long Term Disability premium payment should resume if the employee returns to Long Term Disability coverage eligibility status.

How Will I Be Billed?

You will receive a Group Monthly Premium Adjustment Report. This report will detail current enrollment information for all insured employees as well as premium due us. Complete this report when adding, deleting, or changing benefit participation on an employee. This report must be included with your premium payment remittance.

When Is Premium Payment Due to CNA?

Your premium payment along with the premium report is due to us by the first day of the month for which it applies. For example, April premium and report are due to us by April 1st.

Please allow 5 business days prior to this date for mailing.

Claims to File Early - Early Intervention

Early intervention on disability claims is an integral part of any disability management program. CNA's Early Intervention Claim Program is provided with your LTD coverage at no additional charge. The program is intended to provide advance notification on claims with potential to exceed the LTD elimination period. By using this service. potential LTD claims can be more effectively managed by CNA, even during the LTD elimination period. This should result in improved service and experience for your program. Advance notification is critical to the success of this program.

Early Intervention is designed to work with you and your existing short-term disability (STD) claims administration program for the specific claims diagnoses stated below.

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Filing an Early Intervention Claim.—Your Role
When an employee is disabled as sult of one of the conditions listed below, claim forms indicated in the section labeled Filing a Claim - Your Role under How Do I Submit a Long Term Disability Claim? should IMMEDIATELY be completed and sent to us after the employee's last day of work.

Chronic Fatigue/Epstein Barr Syndrome

Mental/Psychiatric Disorders

- Repetitive motion injuries (such as Carpal Tunnel)
- Fibromyalgia
- Multiple Sclerosis
- Lupus
- Cardiovascular conditions
- Back surgery

If the claim is found to be appropriate for Early Intervention, a Disability Specialist and Nurse Case Manager will immediately begin processing of the claim.

If the claim is NOT appropriate for Early Intervention, you will be advised as to the reasons why.

How Do I Submit a Long Term Disability Claim?

Disability management and accurate, efficient payment of benefits are what you expect as part of your disability program from CNA. So that we may provide our best service, please read this section carefully.

The following claim instructions should be used in the event:

1. CNA is not your STD insurer/administrator; or

2. CNA is your STD insurer/administrator but the claimant was not eligible for STD benefit payments but is insured for LTD with CNA.

If this claim is eligible for CNA paid STD benefits, it will NOT be necessary to submit a new claim form for LTD benefits. We will notify the employee that benefits will begin to be paid on a monthly basis and will be paid under the Long Term Disability (LTD) provisions of the policy. If additional information is needed, we will contact you, the employee or the employee's doctor.

Filing a Claim

When an employee's disability (including disabilities caused by occupation related sickness or injury) is likely to continue beyond the elimination period, the following steps should be followed:

a. Approximately 30 days before the end of the elimination period, send the following material to the disabled employee:

1) the LTD Employee's Statement form. The disabled employee is to complete the entire form;

2) the *Physician's Statement* form. The disabled employee is to complete the identification section and sign the authorization section of the *Physician's Statement* and give the *Statement* to his/her doctor for completion with instructions to return the completed *Physician's Statement* to the employee;

3) the Initial Claim Submission instructions. (You may wish to duplicate the instructions on your company's own

stationery); and

4) a return envelope.
 b. The disabled employee is to send both Statements back to the benefits representative at your company.

c. An authorized representative of your company should:

1) complete the LTD Employer's Statement.

2) provide, in the appropriate spaces on the Statement, the source(s), amount(s) and beginning-ending dates of any other disability, retirement or salary continuance benefits which the disabled employee may be receiving:

submit a job description indicating the physical requirements of the disabled person's job. If you do not have a
job description available, please contact our Claim Department to request a job description for completion;

4) for those employees who are paying all or part of the premium, provide a copy of the disabled employee's LTD enrollment form along with verification that premiums were deducted from the employee's paycheck for this coverage; and

5) provide any additional information that might have an effect on the claim.

d. At least one copy of each Statement should be made for your records.

The forms should be mailed to arrive at least 21 days before the end of the elimination period. Send all information to the address for claim submissions shown in the "Important Addresses" section of this manual. Please note that the submission of the above information will assist us in processing your employees' claims in a timely fashion and will reduce the number of requests needed for subsequent information.

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Claim Processing - Our Role

Initial Claim Processing. When we receive your claim correspondence, we will assign a claim number and advise you of the number. Please use this number whenever you contact us regarding the claim.

To qualify for benefits, an insured employee must:

- a. be disabled during the elimination period and beyond in accordance with the policy provisions; and
- b. meet all eligibility requirements as outlined in the policy.

In addition, premium for the coverage provided under the policy must be paid to date.

Once the elimination period ends, claim payments are made in accordance with the policy provisions. Claim payments will be sent directly to the claimant unless otherwise specified.

If additional information is needed to make the initial evaluation of the claim, we may contact you, the employee or the employee's physician to obtain this information.

Continued Claim Processing. After benefits begin, additional medical information may be necessary to support continued disability and to verify that the claimant is under the appropriate regular care and attendance of a physician. The claimant's condition and the physician's prognosis determine how frequently this information is needed. A claim form is sent to the claimant to have completed and returned. The completion of this form is part of the normal proof required to document the loss.

Social Security and Other Disability Benefits. Your LTD program, together with any other disability benefits, is designed to provide the employee with adequate replacement income. When it is apparent that the employee is entitled to Workers' Compensation, statutory or other benefits, he or she should make prompt application for them. Please call and discuss with us any questions you may have.

If it is likely that the employee's disability will last for 12 full calendar months or more, the policy requires that the employee file for Social Security Disability Benefits. The Claim Department will provide detailed instructions regarding Social Security filing procedures.

The policy also requires that the employee file for all other disability benefits to which the employee is entitled. You should inform us about any other disability benefits that become payable. Include the amounts and dates of payments. Also, please send us copies of the documents the employee receives describing the benefits awarded (or declined), amounts and dates paid.

Additional Information. We may request specific information by correspondence or personal contact from you, the disabled employee, or the employee's attending physician. We will send you copies of correspondence we send to the employee including notification of approval or denial of any claim.

Waiver of Premium. Once we begin benefit payments, you should stop premium payments for the employee, as explained in the Waiver of Premium provision of the policy. When the employee returns to work, you should resume premium payments.

Appeal Procedures. Claim decisions, including denials or termination of benefits, will be communicated directly to the claimant with a copy to your Claim Administrator. Appeals of claim decisions must be made in writing within 60 days of the date the decision was communicated to the employee (the date of the denial letter).

Appeals should be submitted to the Claim Department address shown in the "Important Addresses" section of this manual.

APPEALS SHOULD INCLUDE THE FOLLOWING:

- reason(s) for requesting the appeal; and
- additional documentation in support of the request. This includes objective medical information relevant to the issues and time period surrounding the claim.

The appeal decision will be communicated directly to the person requesting the review. You will also be notified of the decision.

000116



Date				
To:				
Because of your continuing disability, you may be eligible for benefits under your employer's Group Long Term Disability insurance program.				
To file a claim for benefits, the two enclosed STATEMENTS must be completed and returned to us.				
 Complete the top section of the PHYSICIAN'S STATEMENT which identifies you. Make sure that you also sign and date the appropriate spaces for the authorization in this section. 				
2. Next, give the STATEMENT to your doctor to complete and instruct your doctor to return the form to you.				
3. In the meantime, you should complete the LTD EMPLOYEE'S STATEMENT and hold this form until you receive the completed PHYSICIAN'S STATEMENT from your doctor.				
4. Once you receive the completed PHYSICIAN'S STATEMENT from your doctor, return both STATEMENTS to the person named below. The forms will be forwarded to the insurance company.				
You may be contacted by a claim adjuster before a disability benefit can be paid to you. It is in your best interest to cooperate fully to eliminate any delay in processing your claim for benefits.				
If you need additional assistance, call or write:				
Name/Title:				
Address:				
Phone Number:				

How are Long Term Disability Bernetts Taxed?
According to Section 105 of the IRS de, taxation age ratio of an employer's premium de, taxation of benefits is based on the a contributions to total premium (paid for all employees) for the last 3 policy years (or for the term of the policy if less than 3 years). Determine the taxable percentage of a disabled employee's benefits by using the following formula:

Employer premium contributions for last 3 policy years Total premium for last 3 policy years

Benefits attributable to employee contributions made with post-tax income are not taxable. However, benefits attributable to employee contributions made with pre-tax income are taxable.

When your coverage began, we notified our Claim Department of the portion of premium you intended to contribute. If the percentage changes, you must tell us so that we can notify our claim office. If the percentage varies by employee, you must provide the taxable percentage to our claim office when you submit the Initial Claim Report.

Responsibilities for the Payment/Reporting of Taxes

Under current IRS regulations, we will both have certain responsibilities for the payment and reporting of taxes on long term disability benefits.

Your responsibilities:

FUTA/SUTA

You are responsible for paying unemployment taxes at both the federal and state levels. The Sickpay Report (described below) will assist you.

Our responsibilities:

FICA

Section 3121 (a) (4) of the Internal Revenue Code requires that we withhold a disabled employee's portion of the FICA tax from benefit payments made during the first six full calendar months of disability following the month in which the employee's disability begins. After the first six full calendar months, no further FICA deductions are required.

As an additional service to you, CNA will make the matching employer's FICA contribution and report the deposits and the matching contribution on our Form 941. YOU WILL NOT NEED TO PAY THE EMPLOYER'S PORTION OF FICA OR REPORT FICA DEPOSITS TO THE IRS FOR YOUR EMPLOYEES WHO RECEIVE DISABILITY BENEFITS FROM OUR COMPANY. You are only responsible for the FUTA/SUTA taxes as stated above.

FIT/SIT

Section 3402 (c) (4) of the Internal Revenue Code requires that we withhold Federal Income Tax (FIT) from benefits when specifically requested by the claimant. These withholdings will be deposited with the IRS in accordance with IRS requirements.

State Income Tax (SIT) withholding will also be made when specifically requested by the claimant and deposited with the appropriate state agency.

Form W-2

As an additional service to you, CNA will provide a W-2 to each of your disabled employees for the amount of LTD benefits that they receive from us. For your records, we will provide you with a copy of each W-2 mailed to your disabled employees. This service will significantly ease your administrative responsibilities and is provided at no additional cost to you.

If you do not want us to provide a W-2 form to your disabled employees who receive LTD benefits, you will need to notify us in writing. You will then be responsible for (1) paying the employer's matching portion of FICA and reporting these to the federal government; and (2) providing W-2's to each of your disabled employees.

Reports

The Internal Revenue Code, Section 6051 (f) (1), requires us to furnish a written statement that contains the amount of sickpay payments made to each of your disabled employees. To comply with the Law, CNA will provide you with a copy of the Explanation of Benefits (EOB) and the Sickpay Report.

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Explanation of Benefits (EOB)

We will provide an Explanation of the efits each time we make a benefit payment to a disabled employee. The EOB contains the following information:

- Gross benefit amount;
- Amount of FICA withheld;
- · Amount of Federal Income Tax withheld;
- Amount of State Income Tax withheld; and
- Net benefit amount paid.

The EOB is CNA's official tax withholding notification document provided to you as required by IRS law. To ease your work in connection with tax deposit and reporting requirements, we suggest you use the EOB as the input source to your payroll system. In this way, tax deposits relating to disability benefits would become part of your normal tax program and the preparation of year end W-2 forms.

Sickpay Report

Quarterly, we will provide you with a Sickpay Report. The Report contains a year-to-date summary of the information contained in the Explanation of Benefits for each disabled employee and for your company as a whole. The Sickpay Report also contains specific information concerning year to date taxable and non-taxable income and the amount of wages subject to FICA (both Social Security and Medicare) for each individual as well as each claimant's address, social security number and claim number.

If you do not receive a copy of the Sickpay Report or W-2, call our toll-free number (800) 262-6279 and we will send you another copy.

While we are happy to provide these services for your company, each individual employee may have particular tax issues or concerns that need to be addressed. Please encourage these employees to seek advice from personal tax consultants or representatives.

THANK YOU FOR CHOOSING CNA AS YOUR GROUP DISABILITY INSURER.
YOUR COOPERATION IN ADMINISTERING THIS IMPORTANT INSURANCE PROGRAM IS APPRECIATED.

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

))) CASE NO. CV 00-349-E-MHW
) CASE NO. CV 00-349-15-1011W
ORDER
<i>)</i>
<i>)</i>)

Currently pending before the Court for its consideration is Plaintiffs' motion for reconsideration of order (docket # 38), filed November 19, 2001. Having reviewed all briefing submitted, as well as other pertinent documents in the Court's file, and having heard oral arguments, the Court makes its ruling as follows.

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Procedural background.

On October 31, 2001, an Order was issued which dealt with the motions pending at the time (docket #37), including Plaintiffs' motion to amend the complaint, Plaintiffs' motion to compel discovery, and Defendants' motion for determination of the standard of review and for a protective order (against depositions and other discovery requests). At the time the order was

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issued, no apparent responses to the motions had been filed, despite extensions of time having been granted. (It turned out that the parties had each filed responsive briefs on October 29 in Pocatello, however, these were not docketed until November 1.) The October 31 order granted the motion to amend, denied the motion to compel discovery, stated that the standard of review would be in accordance to the Defendants' statement of the law (i.e. abuse of discretion), and granted the Defendants a protective order against discovery.

Plaintiffs filed a motion for reconsideration of the October 31 order as to the rulings on the issues of discovery and the standard of review, arguing that the Court's ruling was in error and not in accordance with the law. Plaintiffs' position is that the plan administrator, who is also the plan's insurer, had an actual conflict of interest which requires the Court to review the decision to deny benefits *de novo*. Defendants deny this and assert that the judicial standard of review should be based on whether the decision was an abuse of discretion or arbitrary and capricious.

II.

Factual background.

The decedent, Carey Hunting, died from respiratory failure secondary to having suffered burns over 90% of his body as the result of an explosion in his home. The explosion and fire occurred on May 20, 1998, and he was hospitalized at the burn center in Salt Lake City from May 21, 1998, until his death on August 2, 1998. At the time of his death, Hunting was an employee of Defendant Idaho Fresh Pak, Inc. which had an employee benefit plan governed by ERISA.

During the course of his hospitalization, Hunting incurred over \$800,000 in medical care costs. Initially, because the explosion and fire at Hunting's home were presumed to have been

accidental, the employee benefit plan paid a little over \$60,000 of the medical bills. Later, however, after investigations by the City of Rigby Police Department, the State Fire Marshal, and the Caribou County Sheriff's office were concluded, the evidence was such that it appeared to the law enforcement agencies that the explosion occurred as the result of an attempted suicide.

Once the plan became aware of the conclusions of law enforcement, and because the employee benefit plan excludes coverage for injuries which are intentionally self-inflicted or attempted suicide, the plan refused to pay any further benefits and sought reimbursement of the costs expended on Hunting's behalf.¹

The house that Hunting reuted was very small and consisted of a bedroom and living room in the front of the house and a kitchen that had been added on at the back of the house off the living room. A small bathroom was accessible at the rear of the bedroom. On the wall that separated the living room and bedroom was a furnace that was powered by propane. A large propane tank sat outside the rear of the house. The furnace is the only appliance in the house that utilized propane. On the day that the explosion occurred, May 20, Hunting ordered \$50 worth of propane to be delivered to his tank in the morning. The tank was noted by the delivery driver to be completely empty. Hunting had not had propane delivered for several months before this, but would usually have \$50 worth delivered each month during the winter.² At the time Hunting ordered the propane, he asked that the driver be told to leave the tank on because the furnace appliance would light itself. However, because it is company policy to turn the tank off, the

It should be noted that Idaho Fresh Pak's exposure for costs under the plan is limited to \$60,000. Benefits under the plan for costs above that amount are insured by an insurance underwriter. Fresh Pak recovered about \$17,000 of the amount of costs it had expended but has been unable to recover more.

Fifty dollars was considered to be the minimum order that the propage company would deliver.

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driver left a note stating that the tank had been turned off, the propane was dispensed, and the tank was left off. The driver noted that the gauge on the tank indicated that it was 40% full at that time. Hunting told the propane company when he placed the order that he would come home at his lunch time to turn it back on.

Late that evening, a huge explosion and fire occurred in Hunting's house. Hunting's next door neighbor was on his front porch at the time it happened and stated that he saw Hunting blown out the front of the house (out of what he thought was the bedroom). When the firemen arrived at the scene on the night of the explosion, they had to turn the propane tank off. Hunting was found approximately 30 feet from the front of the house. The front windows were blown out. The front door was blown off its hinges. The front of the house was blown off the foundation. The bedroom door was also blown off its hinges and into the bedroom. One wall in the kitchen was blown out and the roof over the kitchen collapsed. The propane gas from the furnace was believed to have ignited and caused the explosion but the source of ignition was never determined.

The next day, Hunting's brother was accompanied by a Rigby police officer to the site.

The brother was hoping to locate the keys to Hunting's car as well as his wallet. Although everything inside the home had been consumed by the fire, they found a pair of jeans under the bedroom door which had Hunting's keys and wallet in a pocket. Because the bedroom door had been blown off its hinges and lay on the bedroom floor, it protected the jeans from burning.

In addition to the jeans, however, they also discovered a 27" length of garden hose that ran under the door. It was charred at each end and the rest of it that was not protected by the door

being on top of it had obviously melted in the fire. This caused the police officer to become suspicious and he requested that the State Fire Marshal investigate.

At the scene, the Fire Marshal discovered that the connecting gas line leading from the propose tank to the furnace had been disconnected from the furnace, so the connection between the furnace and the tank was not complete although the tank was turned on and the thermostat had been turned up. The Marshal also noticed a burn pattern on the floor from the area in the bedroom where the hose was found that led across to the furnace. The Fire Marshal also found the "female" end of the garden hose lying next to the connecting hose of the furnace. The remainder of the garden hose had melted. The brass end, however, remained intact. It was not found attached to the connecting hose but the Fire Marshal allowed as to how it would have made a "snug" connection to the gas connecting hose.

The Fire Marshal concluded that the gas line was disconnected to the furnace and connected to the garden hose, which was run into the bedroom, and gas was allowed to accumulate until it was ignited, causing the explosion and fire.

The Rigby Police Department conducted interviews with Hunting's family and friends about his mood and whereabouts prior to the explosion. Several people stated that Hunting had been drinking heavily in the days before, that he was a manic-depressive who had been off his medication for several months, and that he made statements that he "had a date with a train" or that he had considered trying to run his car off the road. Hunting's ex-wife stated that he visited her and their children and told them that he was going away and that they would never see him again. The ex-wife reported this to the Caribou County Sheriff and they had attempted to locate him to do a welfare check, but were unable to find him. One evening, Hunting's niece and

another friend, Larry Cripps, attempted to get Hunting sobered up an, although they felt was over being suicidal by the next day, Cripps remained concerned. On the day of the explosion, Cripps drove by Hunting's house several times to check on him, but never saw Hunting's car there.

Hunting actually was home that evening, but had parked his car about a block away at a store.

As stated, the third-party plan administrator initially paid Hunting's medical bills. The third-party plan administrator is IEC Benefit Administrators, Inc. IEC is only responsible for processing claims and making payments, but it does not make coverage decisions under the plan. A board of three Fresh Pak employees is in charge of making coverage decisions under the plan. In December, 1998, after the plan received the reports from the three law enforcement agencies, the three-member board determined that the claims for Hunting's medical care should be denied because they were incurred as a result of intentional self-injury or attempted suicide, which is excluded from coverage under the plan.

Fresh Pak sent a notice of denial of benefits to Hunting's estate at his last known post office box address. At that time, no estate administrator had been established, however, so the estate claimed that it never received this denial. Sometime in 1999, the estate submitted an administrative appeal of the plan's denial of benefits. On September 8, 2000, the plan administrators issued a written decision affirming the denial of coverage on the ground that the medical expenses arose out of a suicide attempt.³

On November 1, 2000, the Hunting estate requested to reopen the administrative appeal process and have a "second review" of the plan's decision to deny benefits. Although the plan administrators indicated that they considered the decision of September 8, 2000, to have been a

This suit was filed on June 22, 2000, prior to the completion of the administrative appeal process.

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final decision, they nonetheless decided to grant the estate's request. In the estate's second request, it offers explanations for a number of the factual circumstances, such as why the gas connecting hose was disconnected, why there was a garden hose in the house, etc., to show how these factors were actually inconsistent with the idea that Hunting was attempting suicide. The estate also presents the report of a forensic scientist who tested the length of garden hose that was found in the bedroom and concluded that the garden hose did not contain any residue of propane gas. On January 23, 2001, the plan administrator issued its second written decision reaffirming the denial of coverage on the ground that the medical expenses were the result of Hunting's suicide attempt.

ш.

Plaintiffs' motion to reconsider.

The Court finds that there is good cause to reconsider the order issued on October 31, and Plaintiffs' motion to reconsider will be granted. The reconsideration will be limited to the issues of whether Plaintiffs should be allowed to conduct discovery and what the standard of review will be.

IV.

Plaintiffs' motion to compel

and

Defendants' motion for determination of the standard of review.

At the heart of the issues is what standard of review is to be employed in this case.

Plaintiffs argue that, because the plan administrator is also the plan's insurer, an actual conflict exists which affected the decision to deny benefits, so the estate is therefore entitled to have the

Court employ a less deferential *de novo* standard of review. The Defendants argue that no actual conflict existed under the facts of this case and that the Plaintiffs are only entitled to the abuse of discretion standard of review by the Court.

This ERISA case is unusual in that, based on the Plaintiffs' arguments, before the proper standard of review can be determined, the issue of the apparent conflict of interest must be resolved. Typically, where a benefit plan gives the administrator or fiduciary the discretionary authority to determine eligibility for benefits or to construe the terms of the plan, the Court will review the exercise of that discretion of deny benefits for abuse of discretion. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989); and Winters v. Costco Wholesale Corp., 49 F.3d 550, 552 (9th Cir. 1995), quoting Taft v. Equitable Life Assurance Soc'y., 9 F.3d 1469, 1471 (9th Cir. 1993).

However, if the plan administrator is also the insurer, "that conflict [of interest] must be weighed as a 'factor in determining whether there is an abuse of discretion'." Snow v. Standard Ins. Co., 87 F.3d 327, 330 (9th Cir. 1996), quoting Firestone, 489 U.S. at 115. A review where such a conflict of interest exists is "less deferential" although still for abuse of discretion. See Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc., 125 F.3d 794, 798 (9th Cir. 1997), citing Snow, 87 F.3d at 331.

If, however, the beneficiary presents "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary," Lang, 125 F.3d at 798, quoting Atwood v. Newmont Gold Co., 45 F.3d 1317, 1322 (9th Cir. 1995), then a rebuttable presumption arises in favor of the beneficiary. The plan the "bears the burden of rebutting the presumption by

producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits." *Id.* If the plan fails to carry its burden of rebutting the presumption, then the judicial review is based on a *de novo* standard. *Id.*, quoting Atwood, 45 F.3d at 1323.

In this case, Fresh Pak both funds the plan and acts as the plan's administrator as to decisions about benefits. This is the apparent conflict of interest that Plaintiffs roly on to argue that they are entitled to a *de novo* review. Plaintiffs have not actually presented any evidence as to why they believe that the apparent conflict rises to the level of an actual conflict, however, they want to engage in discovery in order to determine the impact of the actual conflict. It is up to the Court to decide whether there is sufficient "material and probative evidence" to trigger a rebuttable presumption that Fresh Pak had an actual conflict of interest which affected its decision to ultimately deny Hunting any benefits. This is the threshold issue which must be decided before the Court can determine what standard of review to apply to the decision-making process.

Plaintiffs rely on two recent Ninth Circuit cases to support the proposition that the Court is required to allow them to present evidence outside the administrative record so that the Court can determine the effect that the Defendants' apparent conflict of interest had on the decision to deny benefits: Regula v. Delta Family Care Disability Survivorship Plan, 266 F.3d 1130 (9th Cir. 2001); and Tremain v. Bell Industries. Inc., 196 F.3d 970 (9th Cir. 1999). In Regula, the appellate court stated:

Because in this case Delta acted as both administrator and funding source for the plan, and evidence of this conflict was before the district court at the time of summary judgment, the district court should have determined whether the apparent conflict of interest was indeed serious enough to have resulted in a breach of fiduciary duty before choosing the appropriate standard of review to be applied to the Plan's disability determinations. Thus, the court erred in failing

even to consider whether Regula provided or could provide material, probative evidence of a breach of fiduciary duty.

Regula, 266 F.3d at 1145 (emphasis added). In an instance where a plaintiff raises the issue of apparent conflict, it appears that Regula requires that the judicial assessment of an apparent conflict be managed through a burden-shifting scheme and that the parties must be permitted the opportunity to present evidence and arguments regarding the fulfillment of their respective burdens, Id. at 1146, including the opportunity to present additional evidence regarding the alleged conflict of interest, so as "to enable the full exercise of informed and independent judgment." Id. at 1147 (citations omitted). De novo review of a plan that, as here, gives discretion to an administrator remains inappropriate unless the plan beneficiary's estate comes forward with material, probative evidence to show that the administrator's self-interest caused a breach if the fiduciary obligation to the beneficiary. Id. at 1146 (citations omitted). If the estate meets its burden, then the Defendants could rebut the evidence by showing that its decision to deny benefits was supported by specific, legitimate reasons that are based on substantial evidence in the record. Id. at 1147.

The Court has considered the Defendants' argument that the apparent conflict of interest was not actual because it did not affect its decision to deny benefits as they had no financial self-interest in the decision to deny the benefits. They point to the fact that Fresh Pak's exposure in this case was limited to \$60,000, which they consider to be a small amount, and that the plan pays many claims every year without question. The Court has also read and considered the Defendants' supplemental post-hearing brief regarding whether they could have interviewed Hunting in the hospital before his death.

The Court agrees that this information, coupled with the reports by three separate law enforcement agencies, would tend to support Defendants' argument that Plaintiffs have not shown sufficient material and probative evidence to trigger a rebuttable presumption that Fresh Pak's apparent conflict affected its decision to deny benefits. However, this is not the proper manner in which the issue is to be determined. The *Regula* decision appears to mandate that the Court is required to allow the Plaintiffs to present additional evidence, including evidence from outside the administrative record, in order to determine the effect of the apparent conflict of interest. After much consideration, and recognizing that this case is in a very unusual posture for an ERISA matter, the Court is compelled by the decision in *Regula* to allow Plaintiffs to conduct a limited amount of discovery for the purpose of inquiring into the areas stated at the hearing, such as what did the plan administrators know and when did they know it.

Accordingly, the Court will allow Plaintiffs to take one deposition of one of the three plan administrators of Plaintiffs' choosing. After that, the parties will be given time in which to submit their arguments as to whether the apparent conflict of interest was an actual conflict that affected the plan administrators' decision to deny benefits and, based on that, what standard of review should be employed. If there is no probative evidence that the apparent conflict had an impact upon the plan administrators' decision, then the case will proceed as an administrative review case under the abuse of discretion standard on summary judgment proceedings. If, on the other hand, Plaintiffs establish probative evidence of an actual conflict that the Defendants cannot rebut, then the case would proceed to a trial de novo.

ORDER. Based upon the foregoing, the Court being fully advised in the premises, IT IS HEREBY ORDERED that: Plaintiffs' motion for reconsideration of order (docket #38), filed November 19, 1) 2001, is GRANTED. Plaintiffs' motion to compel discovery (docket #25), filed September 4, 2001, is 2) GRANTED to the limited extent that Plaintiffs shall be allowed to take one deposition of one of the three plan administrators of Plaintiffs' choosing. This discovery must be completed within the next thirty (30) days, or no later than Wednesday, March 20, 2002. Plaintiffs shall be required to submit a brief on the issues of apparent/actual 3) conflict of interest and the standard of review (as discussed above) no later than Friday, April 12, 2002. Defendants shall submit their brief in response no later than Monday, May 6, 4) 2002. Defendants' motion for leave to file post-hearing supplemental brief (docket 5) # 46), filed February 7, 2002, is GRANTED. Because this case has been reassigned, the trial currently set to commence on 6) Tuesday, March 12, 2002, before the Honorable Edward J. Lodge is hereby VACATED. DATED: February 9 , 2002. UNITED STATES MAGISTRATE JUDGE Order - Page 12